UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Benjamin Holmes
P.O. Box 891 Bronx N.Y. 10451
Write the full name of each plaintiff.

18CV8759
(Include case number if one has been assigned)

-against-

The City of New York and The state of New York Workers Compensation and New York Park's and Recreation
Write the full name of each defendant. If you need more space, please write "see attached" in the space above and attach an additional sheet of paper with the full list of names. The names listed above must be identical to those contained in Section II.

COMPLAINT

Do you want a jury trial?
☑ Yes ☐ No

NOTICE

The public can access electronic court files. For privacy and security reasons, papers filed with the court should therefore *not* contain: an individual's full social security number or full birth date; the full name of a person known to be a minor; or a complete financial account number. A filing may include *only*: the last four digits of a social security number; the year of an individual's birth; a minor's initials; and the last four digits of a financial account number. See Federal Rule of Civil Procedure 5.2.

I. BASIS FOR JURISDICTION

Federal courts are courts of limited jurisdiction (limited power). Generally, only two types of cases can be heard in federal court: cases involving a federal question and cases involving diversity of citizenship of the parties. Under 28 U.S.C. § 1331, a case arising under the United States Constitution or federal laws or treaties is a federal question case. Under 28 U.S.C. § 1332, a case in which a citizen of one State sues a citizen of another State or nation, and the amount in controversy is more than $75,000, is a diversity case. In a diversity case, no defendant may be a citizen of the same State as any plaintiff.

What is the basis for federal-court jurisdiction in your case?

☐ **Federal Question**

☑ **Diversity of Citizenship**

A. If you checked Federal Question

Which of your federal constitutional or federal statutory rights have been violated?

_____

_____

_____

_____

B. If you checked Diversity of Citizenship

1. Citizenship of the parties

Of what State is each party a citizen?

The plaintiff, Benjamin Holmes, (Plaintiff's name) is a citizen of the State of

558 Grand Concrs 891 Bronx NY. 10451
(State in which the person resides and intends to remain.)

or, if not lawfully admitted for permanent residence in the United States, a citizen or subject of the foreign state of

_____.

If more than one plaintiff is named in the complaint, attach additional pages providing information for each additional plaintiff.

If the defendant is an individual:

The defendant, _____, is a citizen of the State of
(Defendant's name)

_____

or, if not lawfully admitted for permanent residence in the United States, a citizen or subject of the foreign state of

_____.

If the defendant is a corporation:

The defendant, _____, is incorporated under the laws of

the State of _____

and has its principal place of business in the State of _____

or is incorporated under the laws of (foreign state) _____

and has its principal place of business in _____.

If more than one defendant is named in the complaint, attach additional pages providing information for each additional defendant.

II. PARTIES

A. Plaintiff Information

Provide the following information for each plaintiff named in the complaint. Attach additional pages if needed.

Benjamin — Holmes
First Name Middle Initial Last Name

897 558 Grand Concourse
Street Address

Bronx New York 10451
County, City State Zip Code

347-313-6258
Telephone Number

Benmack786@gmail.com
Email Address (if available)

B. Defendant Information

To the best of your ability, provide addresses where each defendant may be served. If the correct information is not provided, it could delay or prevent service of the complaint on the defendant. Make sure that the defendants listed below are the same as those listed in the caption. Attach additional pages if needed.

Defendant 1:

First Name Last Name

Current Job Title (or other identifying information)

Current Work Address (or other address where defendant may be served)

County, City State Zip Code

Defendant 2:

First Name Last Name

Current Job Title (or other identifying information)

Current Work Address (or other address where defendant may be served)

County, City State Zip Code

Defendant 3:

First Name Last Name

Current Job Title (or other identifying information)

Current Work Address (or other address where defendant may be served)

County, City State Zip Code

Defendant 4:

First Name Last Name

Current Job Title (or other identifying information)

Current Work Address (or other address where defendant may be served)

County, City State Zip Code

III. STATEMENT OF CLAIM

Place(s) of occurrence: 1 - Bona River Parkway Bronx N.Y. 10462 - happened on Pelham Parkway

Date(s) of occurrence: 5/27/06 - 7/03/06 (may / Jun) 8-16-06

I was hospitalized at the Time

FACTS:

State here briefly the FACTS that support your case. Describe what happened, how you were harmed, and what each defendant personally did or failed to do that harmed you. Attach additional pages if needed.

I was harmed By The Parks Department and The H.R.A. Wend I gave them the notes from the doctors. Said no Heavy Lifting or Pushing. The doctor on 6/3/99 I totally disabled. but they still insist for me to work telling me that's this is a program to see if I Can work. I keep Complaining about me being Sick. and they didn't pay it mine. H.R.A tell me if I don't go to the appointment they were going to stop my Food Stamp and my rent and Medicaid. I had a letter from Social Security telling H.R.A to pay my rent and give me Food Stamp and Medical Assistant. I went to Work with me getting sick. The doctor in Monterfiore Hospital tell me that I need a heart valve. I was stell tryng to work.

The attorney that was representing he did not put the right papers in at workmans Compensation board disallowed my case. because they did not have the paper from the hospital. if this not violating my constitutional rights well they are breaking the law. I would like to Attend all hearings because if a document needed

INJURIES:

If you were injured as a result of these actions, describe your injuries and what medical treatment, if any, you required and received.

This tragic thing that happened to me cause me to die on the table twice went the doctor operate on me. I have take lots of medication for the rest of my life in a wheelchair. I was a normal person before this. I am taking diluted rat poison.

IV. RELIEF

State briefly what money damages or other relief you want the court to order.

I get weak and dizzy most of the time. I have other things is wrong with me. I have two hernias These things was not wrong with me before the operation Money and damages pain and suffering I am asking The Courts to order to reward me $5 million dollar to me thank you

Benyon Halma

9/24/18

V. PLAINTIFF'S CERTIFICATION AND WARNINGS

By signing below, I certify to the best of my knowledge, information, and belief that: (1) the complaint is not being presented for an improper purpose (such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation); (2) the claims are supported by existing law or by a nonfrivolous argument to change existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Federal Rule of Civil Procedure 11.

I agree to notify the Clerk's Office in writing of any changes to my mailing address. I understand that my failure to keep a current address on file with the Clerk's Office may result in the dismissal of my case.

Each Plaintiff must sign and date the complaint. Attach additional pages if necessary. If seeking to proceed without prepayment of fees, each plaintiff must also submit an IFP application.

9/24/18
Dated

Benjamin Holmes
Plaintiff's Signature

First Name	Middle Initial	Last Name
Benjamin		Holmes

Street Address
P.O. Box 891

County, City	State	Zip Code
Bronx	N.Y.	

Telephone Number

Benmack786@gmail.com
Email Address (if available)

I have read the Pro Se (Nonprisoner) Consent to Receive Documents Electronically:
☑ Yes ☐ No

If you do consent to receive documents electronically, submit the completed form with your complaint. If you do not consent, please do not attach the form.

To whom it may concern my name is Benjamin Holmes I am makeing a complaint against The City of New York and The state of

New York.The CITYof NEW YORK Parks and Recreation The Arsenal cental Park New York New York.Move over The Parks and Recreation and workmans

compensation This allow my claim. I have all document that I am in the rights by law of United States I am sending all copies I had a heart attack in 2005

the Hospital I went to was Bronx Lebanon I have a letter from the hospital I also a letter from a doctor Albert Graziosa M D at Throgs Neck Multi Care P C

3058 East Tremont Avenue Bronx New York 10461 call 718-409 0500 this was in 4/30/99 to 6/11/99 after all this social services work assignment and tall

me that it was mandatory I worke as I work I was bleed ing every day.At the end of the work trials I start bleeding more than every the Parks department

supervisor tall Me to go home when I showed the sick notice . I was A wall on the for not comeing to work but I had doctor notes that I was in the hospital.

I accumulate this problem while I was working. The doctors at Montefiore Hospital tall Me that I need a mechanical vlave. The doctor if I don;t have this

procedure perform this surgery that I would become a vegetables He means that I will be in bed for the rest of my life. We discuss the procedure that have

to take some tests after the test he schedule me for surgery. I wont to know how could you force someone back to work and you are not responsible.I guess

it,s back to slavery time whit out the whip I wont to no how cane you be forced back to work

8/4/18

and the person is not responsible. Maybe the law has

change. I am ashing for equal opportunity I asking the court for to let me be at all court hearing because I had a case throw out of court because case was seal

I dont wont this happen again I have all document containing to this case. I am asking the City of New York and the state to restore all my loss income and for

pain and suffering I am sending some documents to show that I am right. Thank you
Benjamin Holmes

P. O. **Box 891**

Bronx N Y 10451

Phon 347-3136258

Benjamin Holmes 8/4/18

To Your Honor

I put all of the document that I can find right now . I put all document from the parks department Doctor notes Hospital records letter from the

Worker ,s Compensation Board from the Law Offices of Joseph A Romano this the attorney that represent me in this cases He did not do a good

job. and social security telling me to go to H R A this should prove that I was in the right . This is why I would like to attend all hearing because if

a document is needed I can present it.

Benyu Hahn
9/24/18

A81

SRINIVASA R. ADAPA M.D.
3950 White Plains Road
Bronx, NY 10466
Tele: 718-882-2432
Fax: 718-231-1067

01/22/2018

REF: Benjamin Holmes
558 Grand Concourse
Bronx, NY 10451
DOB: 04/19/1953

To Whom It May Concern:

Mr. Benjamin Holmes is a 64 year old African American male who has been under my care since 10/04/2017. The patient suffers from multiple medical problems and takes alot of medications. Mr. Holmes is disabled due to his back injury and heart problem. As he is taking coumadin, he should avoid vitamin k rich goods for which he was educated on.

Please assist my patient to apply for food stamps.

Thank you in advance.

Sincerely,

S.R. Adapa, M.D.

Final Diagnoses:
HYPERTENSION, H/O HEART ATTACK IN 2005 MARCH
Accommodations Required For Employment:
Limited Lifting; Limited Pulling; Limited Pushing;
Employment Disposition:
Medical Limitations To Employment That Require Vocational Rehabilitation, and/or Specialized Supports
Narrative Supporting Recommendation:
PT IS A 52 YO AAM WITH H/O HYPERTENSION AND HEART ATTACK IN MARCH 2005 IS CLEARLY STABLE AT THIS TIME WITHOUT ANY CHEST PAIN , SOB OR ANY PHYSICAL FINDINGS ON EXAM.PT NEEDS VOC REHAB FOR STABLIZATION, FUNCTIONAL IMPROVEMENT AND FOR WORK READINESS.PT CAN NOT HEAVY LIFTING OR PUSHING JOB BUT CLEARLY IS ABLE TO DO LESS EXERTIONAL JOB.
Comments:
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(Completed 10/26/2005 By M. Shuja, , Bronx Lebanon Hospital)

Medical Conditions Impacting Or Requiring Stabilization For Employment

Date Identified	Domain	Diagnosis Affecting Employment	Recommended Treatment/ Action Plan	Target Date
10/26/2005	Medical	HYPERTENSION	PCP	
10/26/2005	Medical	H/O HEART ATTACK	PCP/ CARDIOLOGY	

(Completed 10/26/2005 By M. Shuja, , Bronx Lebanon Hospital)

Medical Needs Not Affecting Employment

Referral Needed For PCP - Routine: Yes
Referral Needed For PCP - Emergent? No
Referral Needed For ER? No
Comments:
--
(Completed 10/26/2005 By M. Shuja, , Bronx Lebanon Hospital)

ALBERT GRAZIOSA, M.D.
ORTHOPAEDIC SURGEON
THROGS NECK MULTI CARE, P.C.
3058 EAST TREMONT AVENUE
BRONX, NEW YORK 10461
(718) 409-0500

DISABILITY CERTIFICATE

DATE: 6/2/99

To Whom It May Concern:

This is to certify that:

Holmes Benjamin

has been under my care for:

Lumbosacral S/Sprain w/poss' lumbar Radiculopathy

The patient has been totally incapacitated:

FROM: 4/30/99 TO: 6/11/99

partially incapacitated:

FROM: _____ TO: _____

REMARKS: Patient is totally disabled for the above period of time. He will be re-evaluated on 6/11/99. Any questions feel free to call our office.

Albert Graziosa

ALBERT GRAZIOSA, M.D.

ALBERT GRAZIOSA, M.D.
ORTHOPAEDIC SURGEON
THROGS NECK MULTI CARE, P.C.
3058 EAST TREMONT AVENUE
BRONX, NEW YORK 10461
(718) 409-0500

--

Final Diagnoses:

HYPERTENSION, H/O HEART ATTACK IN 2005 MARCH

Accommodations Required For Employment:

Limited Lifting; Limited Pulling; Limited Pushing;

Employment Disposition:

Medical Limitations To Employment That Require Vocational Rehabilitation, and/or Specialized Supports

Narrative Supporting Recommendation:

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Comments:

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(Completed 10/26/2005 By M. Shuja, , Bronx Lebanon Hospital)

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Referral Needed For PCP - Emergent? No

Referral Needed For ER? No

Comments:

--

(Completed 10/26/2005 By M. Shuja, , Bronx Lebanon Hospital)

This is the papers to proof that I in the that the hospital it shows that workers compensation Board round whit thay decision the doctors did not fill

out the workers compensation papers. on 8/15/ 18 I went to Montefiore Hospital to ask them why workers compensation was not fill out by the doctors

I am seeking my full workman comp payments for 11 years .

Thank You

Benjamin Holmes

P O Box 891

Bronx New York 10451

Phon-347-313-6258

This is the papers to proof that I in the that the hospital it shows that workers compensation Board round whit thay decision the doctors did not fill

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Thank You

Benjamin Holmes

P O Box 891

Bronx New York 10451

Phon-347-313-6258

MONTEFIORE

Moses Emergency Department
111 East 210th Street
Bronx, NY 10467
718.920.5731

Patient: HOLMES, BENJAMIN
Triage Date: October 16, 2006
DOB: April 19, 1953
Med Rec#:
Account#:

HOLMES, BENJAMIN
MR#01287053 ED
MOSES
DOB: 04/19/1953
ACCT: 154594550

Emergency Department Consent, Page 1

I, _____, hereby give my voluntary consent to _____
of the following procedure upon _____
I certify that the above procedure has been explained to me as well as its risks, benefits and alternatives and all my questions have been answered. I understand the diagnostic or treatment necessity for the procedure(s).

Procedure to be done: EXAMINATION & TREATMENT
Signed _____ Relationship to patient _____ Date _____ Witness

DISCHARGE AGAINST ADVICE

I, _____, am voluntarily leaving and signing out _____
_____, I am taking _____ from the Montefiore Medical Center against the advice of my physician and/or the Medial Staff. In demanding this discharge, I hereby release my physician, the Hospital, and its staff from any and all responsibility for the care, treatment, or condition of the above named patient.

Witness _____ Signed _____

Approved by O.O.D. _____ Relationship to patient _____

WORKERS COMPENSATION

I, _____
Address _____
Hereby authorize Montefiore Medical Center, Bronx, N.Y. to release any and all information concerning
to _____

Signature _____

PRINTED BY: WPHIPPS DATE: 12/16/2009

Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

PATIENT'S NAME: HOLMES, Benjamin
MR NUMBER: 01287053
SURGEON'S NAME: JOSEPH DEROSE, M.D.
DATE OF SURGERY: 06-05-2007
TYPE OF REPORT: OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Mitral Regurgitation

POST-OPERATIVE DIAGNOSIS: same

OPERATION: Mini-mitral valve replacement

SURGEON: Joseph J. DeRose, Jr., MD

ASSISTANT: Joseph Rabin, MD

PATHOLOGY: The patient is a 54 year-old man with a PMHx of HTN and a strong family history of CAD who was admitted to the hospital 3 weeks ago with chest pain and SOB. Echocardiogram revealed severe MR with a restricted anterior leaflet consistent with prior rheumatic disease. Cardiac catheterization revealed no evidence of CAD and confirmed the MR with moderate pulmonary hypertension. At operation the anterior leaflet was forshortened and scarred. The commissures were fused and the posterior leaflet was likewise restricted. Mitral Valve Replacement: 25/33 ON-X (mechanical)

POCEDURE: After the induction of general double lumen endotracheal anesthesia, the patient was positioned in an anterolateral thoracotomy position with the right arm supported on a pillow over the head. The chest and groins were prepped and draped in the usual sterile manner.

A 5 cm anterolateral thoracotomy incision was made in the 5th interspace. The pericardium was opened and suspended with pericardial sutures. Next a small incision was made in the right groin and the femoral artery and femoral vein were dissected free. ACT guided heparinization was then administered and the femoral artery was cannulated via a Sledinger technique with a 20 Fr Fem-Flex cannula. Next the femoral vein was cannulated with a 22 Fr Cardiovations cannula which was passed to the SVC/RA junction under echo guidance.

An antegrade cardioplegia cannulae was inserted into the aorta. Cardiopulmonary bypass was initiated. Sonnengard's groove was dissected. A Chitwood clamp was inserted through the axilla and after

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DATE OF SURGERY: 06-05-2007
TYPE OF REPORT: OPERATIVE REPORT

temporarily reducing the pressure, the aorta was cross-clamped. One liter of cold blood cardioplegia was administered antegrade. Cardioplegia was re-infused at 20-minute intervals throughout the procedure.

The left atrium was then opened, and the mitral valve was exposed with the Estech atrial lift retractor. The anterior leaflet was restricted and foreshortened. The anterior leaflet was divided but the majority of its chordal attachments were retained and plicated with the valve sutures. The posterior leaflet was likewise retained in its entirety. Pledgeted 2-0 Ticron sutures were then placed on the atrial side through the annulus in a mattress style and the valve was sized to a 25/33 ONYX mechanical vlave. The valve was easily seated and the sutures were secured. The atriotomy was then closed with running 3-0 prolene.

Evacuation of air was performed and with high suction applied to the aortic root vent, the aortic clamp was released. Organized rhythm was restored. Deairing maneuvers were completed and the patient was separated from the CPB circuit.

Two right ventricular pacing wires were placed. Drainage tubes were placed in the pericardium and in the right pleural space. The cannulas were removed and protamine was administered. A soaker catheter was placed in the paravertebral space for postoperative analgesia.

The fascia, subcutaneous tissue and skin were then closed with absorbable sutures in layers. Sterile dressings were applied and the patient was transferred to the ICU in stable condition.

Dr. DeRose was scrubbed for all portions of this operation.

Details of CPB:

CPB:	134 minutes
x-clamp:	103 minutes
Blood products:	none

Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

PATIENT'S NAME: HOLMES, Benjamin
MR NUMBER: 01287053
SURGEON'S NAME: JOSEPH DEROSE, M.D.
DATE OF SURGERY: 06-05-2007
TYPE OF REPORT: OPERATIVE REPORT

DICTATED BY: JOSEPH DEROSE, M.D.

JOSEPH DEROSE, M.D.

D: 06/12/2007 T: 06/13/2007 PMC/JA J: 19701 DT:6:02 PM
A: 162893440
Page 3 of 3
Authenticated and Edited by Joseph J Derose, MD On 6/14/07 9:23:53 AM

Montefiore

Burke Avenue
941 Burke Avenue Bronx, NY 10469
(718) 654-5900 Fax: (718) 654-0053

Patient Information

For: Benjamin HOLMES
DOB: 04/19/1953 **MRN:** 01287053

*Patient Instructions

Coumadin as per MD on Sat/Sun
2) COUMADIN 1 MG TABS (WARFARIN SODIUM) one mg tabs to be takin as instructed by MD with 5 mg coumadin talbets
3) LOVENOX 150 MG/ML SOLN (ENOXAPARIN SODIUM) Take Lovenox 150 mg SQ daily
4) MEPHYTON 5 MG TABS (PHYTONADIONE) TAke only when directed
5) TOPROL XL 50 MG XR24H-TAB (METOPROLOL SUCCINATE) 1 TAB BID PO
6) PROCARDIA XL 90 MG XR24H-TAB (NIFEDIPINE) 1 TAB QDAY PO
7) HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 TAB QDAY PO
8) LYRICA 100 MG CAPS (PREGABALIN) two three times a day
9) ZOCOR 40 MG TABS (SIMVASTATIN) one at bed time Brand Only
10) PRILOSEC 20 MG CPDR (OMEPRAZOLE) one tablet daily
11) ATROVENT HFA 17 MCG/ACT AERS (IPRATROPIUM BROMIDE HFA) two puffs 4 times a day
12) VITAMIN D (ERGOCALCIFEROL) CAPS 2000 UNITS one per day after completing high dose vit d
13) COLACE 100 MG CAPS (DOCUSATE SODIUM) 1 CAP TID. PO
14) STANDARD METAL WHEEL CHAIR WITH FOOT REST Use when balance is poor to prevent falls
15) FLOVENT HFA 110 MCG/ACT AERO (FLUTICASONE PROPIONATE HFA) one puff twice a day
16) DOCUSATE SODIUM 100 MG TABS (DOCUSATE SODIUM) one tablet three times a day
17) CIALIS 10 MG TABS (TADALAFIL) one tablet every 36 hours

Please contact us at (718) 654-5900 if you have any questions or concerns.

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S REQUEST FOR FURTHER ACTION

INSTRUCTIONS: To request Board action on a case, complete this form and submit it to your local WCB district office. See mailing addresses on the reverse side. ATTACH ALL APPLICABLE EVIDENCE FOR CONSIDERATION BY THE BOARD. You must also send a copy of this form to your employer's workers' compensation insurance carrier, or directly to your employer or its third party administrator, if it is self-insured. This form is NOT to be used to APPEAL a decision.

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS				
1. WCB CASE NO.	2. CARRIER CASE NO. (If known)	3. SOCIAL SECURITY NO.	4. DATE OF INJURY (m m d d y y)	5. WCB DISTRICT OFFICE
0792583 7	33786765	100 42 3996	04 19 53	

	NAME	ADDRESS TO WHICH NOTICES SHOULD BE SENT
6. CLAIMANT	Benjamin Holmes	1160 Burke Ave. Bronx NY 10469 APT. NO. 3C
7. EMPLOYER	Lows Leon	1140 Grenada Pl. Bronx N.y. 10466
8. CARRIER	The State ,NY Surance Found	199 Church St. N.y. N.y. 10007
9. ATTORNEY OR LICENSED REP.	That's what I want to find out	ATTY/REP I.D. NO. R

CHECK HERE ☒ IF CLAIMANT'S ADDRESS SHOWN ABOVE IS NEW.

REASON FOR THIS REQUEST

(Check all that apply - use item p. for explanation or additional information - see reverse side for further explanation)

10. CLAIMANT

- ☐ a. requests referral for Administrative Determination/Conciliation/Hearing, as appropriate, because *(please check the appropriate box[es] below)*:
- ☒ b. he/she has had a change of medical condition. *IF THIS BOX IS CHECKED, ATTACH MEDICAL REPORT. IF REPORT WAS PREVIOUSLY SUBMITTED, IDENTIFY IT IN ITEM P BELOW BY DATE, DOCTOR'S NAME AND FORM ID, IF ANY.*
- ☒ c. he/she is not working and not receiving payments.
- ☐ d. his/her payments have been suspended/reduced.
- ☐ e. he/she has returned to work at full wages.
- ☐ f. he/she is working at reduced earnings.
- ☒ g. he/she has not been paid as directed in a notice of decision.
- ☒ h. a request for medical treatment was denied or not addressed.
- ☐ i. a request for medical and transportation reimbursement was denied.
- ☐ j. he/she now has medical evidence of permanency.
- ☐ k. new or requested evidence is now available.
- ☐ l. claimant's representative's fee has not been paid.
- ☐ m. he/she has discontinued or settled a lawsuit pertaining to this accident/injury.
- ☒ n. claimant has a change of address (please provide new address in 6., above).
- ☐ o. he/she has been released from incarceration and is applying for benefits (attach proof of release).
- ☐ p. other (explain fully in the space provided below.)

ATTACH ALL APPLICABLE EVIDENCE FOR CONSIDERATION BY THE BOARD. IF MEDICAL EVIDENCE WAS PREVIOUSLY SUBMITTED, IDENTIFY IT BY DATE, DOCTOR'S NAME AND FORM ID, IF ANY, IN THE SPACE PROVIDED ABOVE.

11. Have the above issues been resolved by agreement? ☐ Yes ☒ No If Yes, please attach documentation.
If No, have you attempted to resolve the issue(s) checked above with the other parties? ☐ Yes ☐ No

I hereby certify that a copy of this form with attachment(s) was submitted to the other party(ies) in this case in accordance with the instructions above.

PREPARED BY (Please Print Name)	DATE PREPARED (m m d d y y)	AREA CODE TELEPHONE NUMBER
Benjamin Holmes		917 971 4738

This form is submitted by ☐ claimant ☐ claimant's representative

Columbia Heart

Coronary Angiogram CT Patient Instructions

Name Benjamin Wines Study needed CT Coronary

Indications: abd pain Meds/Food Allergies

Appointment Date: 10-10-08 Time: 845 MR# R1001628 Physician: Phillips

Bring all of your medications and insurance cards with you. You may eat a light breakfast, but avoid caffeine. No smoking for six hours prior to your scan. Take your medications as usual unless other instructions are given.

	MEDICARE CORONARY DX LIST **BC/BS INDICATIONS *BC/BS RISK FACTORS	
	ANGINA DECUBITUS	413.0
	PRINZMETAL ANGINA	413.1
	OTHER AND UNSPECIFIED ANGINA PECTORIS	413.9
	CAD OF UNSPECIFIED TYPE OF VESSEL, NATIVE OR GRAFT**	414.00
	CAD OF NATIVE CORONARY ARTERY**	414.01
	CAD OF AUTOLOGOUS BIOLOGICAL BYPASS GRAFT**	414.02
	CAD OF AUTOLOGOUS VEIN BYPASS GRAFT**	414.03
	CAD OF NONAUTOLOGOUS BIOLOGICAL BYPASS GRAFT**	414.04
	CAD OF ARTERY BYPASS GRAFT**	414.05
	ANEURYSM OF CORONARY VESSELS	414.11
	DISSECTION OF CORONARY ARTERY	414.12
	OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE, UNSPECIFIED	414.8
	CHRONICH ISCHEMIC HEART DISEASE, UNSPECIFIED	414.9
	CORONARY ARTERY ANOMALY, CONGENITAL	746.85
	CHEST PAIN, UNSPECIFIED**	786.50
	PRECORDIAL PAIN**	786.51
	OTHER CHEST PAIN**	786.59
	ABNORMAL CARDIOVASCULAR FUNCTION STUDY, UNSPECIFIED**	794.30

Yes (No) **Allergy to Radiopaque contrast media, iodine or shellfish?**
If Yes, pre-medicate for contrast reaction/shellfish reaction.
Rx: Prednisone: 60mg po @ 10pm the night before the scan and 1 hour before the scan.
Benadryl: 50mg po 1 tablet @ 10pm the night before the scan and 1 hour prior to scan.
Pepcid: 40mg po 1 tablet @ 10pm the night before the scan and 1 hour prior to scan.
OR
Medrol Med Pack (if patient is unable to tolerate prednisone)

(Yes) No Heart rate: 68 Date: 10/2/18
If heart rate is > 70 bpm, PO beta Blockers is indicated.
Rx: Metoprol: 50mg po at 6pm the night prior to scan and 1 hour prior to scan

Yes No Baseline BMP & BUN ordered. **REQUIRED** within 30 days of scan.
Place of service:

Yes (No) Is patient a diabetic?

Yes (No) Is the patient on Metformin, Glucophage, Glucovance or Avandamet. IF yes, instruct patient to hold on the day of the scan.

(Yes) No EKG obtained. **Required** within 30 days of scan. Sinus arrhythmia or atrial fibrillation – Notify Physician.

Yes (No) Does patient have a pacemaker or ICD? If yes, advise patient that the device may be "turned down" immediately prior to the scan and "turned up" immediately follow the scan.

Yes (No) Does the patient suffer form claustrophobia or appear anxious regarding the scan?
If Yes, consider medication for anxiety. (Patient will need to be accompanied by a driver.)
Rx:

Yes (No) If the patient is female and of child bearing age, then a serum Beta Hcg will be done.

Physician's signature Date: 10/8/18

Columbia Heart

Coronary Angiogram CT Patient Instructions

Name Benjamin Hines Study needed CT Coronary

Indications: abd pain Meds/Food Allergies

Appointment Date: 10.10.08 Time: 845 MR# R1001628 Physician: Phillips

Bring all of your medications and insurance cards with you. You may eat a light breakfast, but avoid caffeine. No smoking for six hours prior to your scan. Take your medications as usual unless other instructions are given.

	MEDICARE CORONARY DX LIST **BC/BS INDICATIONS *BC/BS RISK FACTORS	
	ANGINA DECUBITUS	413.0
	PRINZMETAL ANGINA	413.1
	OTHER AND UNSPECIFIED ANGINA PECTORIS	413.9
	CAD OF UNSPECIFIED TYPE OF VESSEL, NATIVE OR GRAFT**	414.00
	CAD OF NATIVE CORONARY ARTERY**	414.01
	CAD OF AUTOLOGOUS BIOLOGICAL BYPASS GRAFT**	414.02
	CAD OF AUTOLOGOUS VEIN BYPASS GRAFT**	414.03
	CAD OF NONAUTOLOGOUS BIOLOGICAL BYPASS GRAFT**	414.04
	CAD OF ARTERY BYPASS GRAFT**	414.05
	ANEURYSM OF CORONARY VESSELS	414.11
	DISSECTION OF CORONARY ARTERY	414.12
	OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE, UNSPECIFIED	414.8
	CHRONICH ISCHEMIC HEART DISEASE, UNSPECIFIED	414.9
	CORONARY ARTERY ANOMALY, CONGENITAL	746.85
	CHEST PAIN, UNSPECIFIED**	786.50
	PRECORDIAL PAIN**	786.51
	OTHER CHEST PAIN**	786.59
	ABNORMAL CARDIOVASCULAR FUNCTION STUDY, UNSPECIFIED**	794.30

Yes (No) **Allergy to Radiopaque contrast media, iodine or shellfish?**
If Yes, pre-medicate for contrast reaction/shellfish reaction.
Rx: Prednisone: 60mg po @ 10pm the night before the scan and 1 hour before the scan.
Benadryl: 50mg po 1 tablet @ 10pm the night before the scan and 1 hour prior to scan.
Pepcid: 40mg po 1 tablet @ 10pm the night before the scan and 1 hour prior to scan.
OR
Medrol Med Pack (if patient is unable to tolerate prednisone)

(Yes) No Heart rate: 68 Date: 10/8/18
If heart rate is > 70 bpm, PO beta Blockers is indicated.
Rx: Metoprol: 50mg po at 6pm the night prior to scan and 1 hour prior to scan

Yes No Baseline BMP & BUN ordered. **REQUIRED** within 30 days of scan.
Place of service:

Yes (No) Is patient a diabetic?

Yes (No) Is the patient on Metformin, Glucophage, Glucovance or Avandamet. IF yes, instruct patient to hold on the day of the scan.

(Yes) No EKG obtained. **Required** within 30 days of scan. Sinus arrhythmia or atrial fibrillation – Notify Physician.

Yes (No) Does patient have a pacemaker or ICD? If yes, advise patient that the device may be "turned down" immediately prior to the scan and "turned up" immediately follow the scan.

Yes (No) Does the patient suffer form claustrophobia or appear anxious regarding the scan?
If Yes, consider medication for anxiety. (Patient will need to be accompanied by a driver.)
Rx:

Yes (No) If the patient is female and of child bearing age, then a serum Beta Hcg will be done.

Physician's signature Date: 10/8/18

Columbia Heart

IF PAYING BY CREDIT CARD, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT

☐ DISCOVER ☐ MASTERCARD ☐ VISA

CARD NUMBER | AMOUNT

SIGNATURE | EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
10/08/08	$0.00	33031

SHOW AMOUNT PAID HERE $

ADDRESSEE:

Holmes, Benjermin
78 Green Circle

Yemassee, SC 29945
USA

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

REMIT TO:

Columbia Heart Clinic
8 Richland Medical Park Drive
Ste 300
Columbia, SC 29203

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
10/08/08				Patient Payment Cash (QTY 1.00)	-$2.00

ACCOUNT NBR	CHARGES	PAYMENTS	REFUNDS/ ADJUSTMENTS	ESTIMATED BALANCE DUE FROM INSURANCE	BALANCE DUE FROM PATIENT
33031	$0.00	-$2.00	$0.00	$0.00	$0.00

MESSAGE:
Thank you for choosing Columbia Heart for your Cardiology needs.

PLEASE PAY THIS AMOUNT »»»»» $0.00

** PAYMENT DUE UPON RECEIPT * THANK YOU **

ENCOUNTER INVOICE

Columbia Heart

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
CHECK CARD USING FOR PAYMENT ☐ DISCOVER ☐ MASTERCARD ☐ VISA		
CARD NUMBER		AMOUNT
SIGNATURE		EXP. DATE
STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
10/08/08	$0.00	33031

SHOW AMOUNT PAID HERE $

ADDRESSEE:

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78 Green Circle

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33031	$0.00	-$2.00	$0.00	$0.00	$0.00

MESSAGE:
Thank you for choosing Columbia Heart for your Cardiology needs.

PLEASE PAY THIS AMOUNT »»»»» $0.00

** PAYMENT DUE UPON RECEIPT * THANK YOU **

ENCOUNTER INVOICE

View Residence Information Section
View Family Violence Section
View Involved with Child Welfare Section
View Legal Involvement Section
View Alcohol/Drug Section
View Mental Health History Section
View Current Mental Health Status Section
View Physician's View

F.E.G.S BIOPSYCHOSOCIAL SUMMARY

Date Prepared (From/To):	01/04/2007 - 01/13/2007	**Page Number:**	1
FEGS Main Track Number:	2505168	**HRA Case Number/Suffix/Line Number:**	0002185592 - 01 - 88
Case Name:	Holmes, Benjamin	**CIN:**	WD86222A
Address:	762 EAST 211TH STREET	**Telephone Number:**	7186521516
	BRONX, New York 10462	**HRA Office Number**	38
Assigned Case Manager	--	**Case Manager Telephone Number:**	--
HRA Special Program	--		

Date of Contact:	01/04/2007	**Staff Member Name:**	Scott Matthew Wallin
Organization/ Unit:	Bronx Lebanon Hospital	**Location:**	Hunts Point Avenue
Telephone Number:	--	**E-Mail Address:**	SWallin@fegs.org

Article 28 Clinic Information

Name/Location of Article 28 Organization Clinic: Bronx Lebanon Hospital - Hunts Point Avenue

Date of Initial BPS Appointment:	--	**Time of Initial BPS Appointment:**	--
Medical Record Number:	3415055	**Clinic Episode Number:**	20049851

(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Releases

Applicant/Participant has signed HRA consent for release of confidential HIV related information.

Applicant/Participant has signed HRA consent for release of medical and alcohol or substance abuse treatment program information.

(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Case Information

SSN:	100-42-3996	**F.E.G.S. Case Status:**	Active
HRA Case Type:	Emergency Assistance to Adult	**HRA Case Status:**	Applicant

Home Phone:	none	**Apartment Number:**	PH
Date of Birth: (MM/DD/YYYY)	04/19/1953	**Cellular Phone:**	646-335-8505
Age:	53	**Place of Birth: (Town, State/Country)**	Buford, SC
Ethnicity:	Black or African American	**Gender:**	Male
		Marital Status:	Divorced

(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Applicant/Participant Language

Speak English?	Yes	**Primary Language:**	--
Bi-Lingual?	No	**Other Language:**	--
Need Translator:	No	**If Yes, Identify Translator:**	--
Translator Name:	--		

(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Emergency Contact

Contact Last Name:	Holmes	**Contact First Name:**	Barbara
Telephone Number:	347-558-8223	**Cell Phone Number:**	--
Street Address:	not available	**City, State, Zip:**	--
Relationship to Applicant/Participant:	Child		

(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Finances of Applicant/Participant

Income Sources:	--
Other Financial Issues:	-- --
Comments:	--

(Not Completed as of 01/04/2007)

Health Insurance Information

Is Receiving:	Medicaid - Pending
Medicaid Number:	WD86222A
Medicaid Managed Care Insurance Plan:	--
Medicare Number:	--
Medicaid Plan:	--
Other Insurance Plan:	--

Primary Care Medical Provider Name:	Lolita Sayseng, MD	**Provider Phone:**	718-920-2273

Provider Street Address: 111 E. 210th Street **City, State, Zip:** Bronx, NY 10467
(Not Completed as of 01/04/2007)

Residence Information

Top
Physician's View

Current Type of Residence: --
Floor Number: --
Elevator? --
Years At Current Address: --
Primary Tenant/Lease Holder? --
If No, Relationship to Primary Tenant: --
Housing Stability:
Comments:
--
(Not Completed as of 01/04/2007)

Household Member Information

Comments:
Name: **Comment:**
(Not Completed as of 01/04/2007)

Relatives Outside Household To Whom Applicant/Participant Provides Assistance/Support

Comments:
Name: **Comment:**
(Not Completed as of 01/04/2007)

Relatives Outside Household From Whom Applicant/Participant Receives Assistance/Support

Comments:
Name: **Comment:**
(Not Completed as of 01/04/2007)

Applicant/Participant's Minor Children Not Living in the Household

Comments:
--
(Not Completed as of 01/04/2007)

Education of Applicant/Participant

Type of Education: -- **Last Grade Completed:** --
Read in English: -- **If No, In What Language?** --
Write in English: -- **If No, In What Language?** --
Have You Ever Been Told You Have a Learning Disability? --
Received Special Education? --
Licenses/Credentials Received:
--

Attending School Now? --
Comments: --
(Not Completed as of 01/04/2007)

Employment History of Applicant/Participant

Level of Work History: --
History of HRA Work Activities (including WEP)? -- **Vocational Goals:** --
Comments: --
(Not Completed as of 01/04/2007)

Family Violence

Top
Physician's View

In the past 3 months:
Have you been slapped, punched, kicked, beaten up or otherwise physically hurt by anyone? No
Have you been witnessed anyone in your household slapped, punched, kicked, beaten up or otherwise physically hurt by anyone? No
Were you forced to have sex against your will or otherwise been sexually abused? No
Issues: --

If Yes, Please Explain: n/a

(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Involved with Child Welfare/ACS? No

Top
Physician's View

(Not Completed as of 01/04/2007)

Urgent Child Welfare/ACS? No

Top
Physician's View

If Yes, Please Explain n/a
If Allegation of Neglect/Abuse, Immediately Discuss Case With Supervisor; Involve HRA Staff as Appropriate; Record Follow-Up Above
(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Legal Involvement of Applicant/Participant

Top
Physician's View

History of Legal Problems: --
On Parole? --
On Probation? --
Outstanding Warrants? --
Currently Involved in: None
Mandated by Court for:
None
Previous Arrest? --
If Yes, Type? --
Previous Conviction? --
If Yes, Type? --
Prior History of Incarceration? --
Comments: --

(Not Completed as of 01/04/2007)

Alcohol/Drug Abuse History of Applicant/Participant

Top
Physician's View

Alcohol Problem History: No History
Drug Problem History: No History

Substance of Choice **Name/Type of Substance:** **Extent of Use:**

Did You Ever Received Treatment? --

Name of Program or Hospital	Type	Year	Length of Time in Treatment

Complying with Treatment? --
Mandated to Treatment? -- **If Yes, By:** --
If CASAC Referral Required, Date of Referral to CASAC: --
If Current or Recent Alcohol/Drug History and No CASAC Referral, Enter Reason: --
Date of CASAC Response: --
Summary of CASAC Response: --
Comments: no info to indicate CASAC referral
(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Mental Health History of Applicant/Participant

Top
Physician's View

Have You Ever Received Treatment for Nerves, Depression, or an Emotional Problem? No

Name of Organization	Year	For How Long (months)	Reason (According to Applicant/Particpant)

Ever Thought About Hurting Yourself? No **Ever Thought About Hurting Others?** No
Ever Tried To hurt Yourself? No **Ever Tried To hurt Others?** No
Comments: no s/i or h/i
(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Current Mental Health Status of Applicant/Participant

Top
Physician's View

Over The Last Two Weeks, How Often Have You Been Bothered By Any One Of The Following Problems?

Feeling down, depressed, or hopeless?	Not at All
Little interest or pleasure in doing things?	Not at All
Trouble falling or staying asleep, or sleeping too much?	Nearly Everyday
Feeling tired or having little energy?	Not at All
Poor appetite or overeating?	Not at All
Feeling bad about yourself or that you are a failure or have let yourself or your family down?	Not at All
Trouble concentrating on things, such as reading the newspaper or watching television?	Not at All

Moving or speaking so slowly that other people could have noticed? Or the

opposite-being so fidget or restless that you have been moving around a lot more than usual? Not at All

Thought that you would be better off dead or hurting yourself in some way? Not at All

PHQ-9 Score Total: **Depression Severity:** None **Proposed Treatment Actions:** None

If you are experiencing any of the problems in this section, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Not Difficult At All

Currently Receiving Mental Health Services? No

Treating Hospital/Clinic/Therapist Name: --

Treating Hospital/Clinic/Therapist Telephone Number: --

Court Mandated Treatment? No

Complying with Treatment? --

Homicidal/Suicidal Behavior? No

If applicant/participant indicates present suicidal ideation or homicidal thoughts, discuss immediately with supervisor.

Comments: n/a
(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Physician's View

View Attachment Index Top

Applicant/Participant Travel(Page 1)

Travel Independently By Bus/Train? Yes
Did the Applicant/Participant Travel Independently to Appointment? Yes
How did the Applicant/Participant Travel to Appointment? Subway;
Travel Limitations/Special Transportation Needs: None;
If Yes, Provide Additional Information For Travel Limitations And Any Comments: --
(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Applicant/Participant Travel (Page 11)

Travel Independently By Bus/Train? Yes
Did the Applicant/Participant Travel Independently to Appointment? Yes
How did the Applicant/Participant Travel to Appointment? Subway;
Travel Limitations/Special Transportation Needs: None;
If Yes, Provide Additional Information For Travel Limitations And Any Comments: --
(Not Completed as of 01/04/2007)

Daily Activities of Applicant/Participant

How do you spend your day? staying in bed, per MD orders
Able to do the following:

Wash Dishes : Yes	**Wash Clothes** : Yes
Sweep/Mop Floor : Yes	**Vacuum:** Yes
Watch TV: Yes	**Make Beds:** Yes
Shop Groceries : Yes	**Cook Meals:** Yes
Read: Yes	**Socialize:** Yes
Get Dressed: Yes	**Bath:** Yes
Use Toilet: Yes	**Groom Yourself:** Yes

Not able to do the following:

Special Hobbies and Leisure Time Activities: none

Have Contact with?

Friends: No

Social Service Agencies: No

Community Organizations: No

Religious Organizations: No

Comments: Unable to do ADLs all the time or quickly, due to heart condition and shortness of breath. Clt's son comes in to help.

(Completed 1/4/2007 By Scott Matthew Wallin, FEGS Social Worker, FEGS)

Social Work Summary

What Strengths Does Applicant/Participant Have(as assessed by interviewer)?

Has Physician; Has Work Skills/History; Travels Independently; Maintains Adequate Grooming/ Hygiene;

Other Skills: auto mechanics

What does Applicant/Participant See as Barriers to Employment?

cardiomyopathy, HTN.

Psychosocial Barriers to Employment:

Date Identified	Psychosocial Barriers or Issues	Recommended Action
01/04/2007	Medical Condition Under Medical Treatment	M.D. to assess

Additional Case Notes by Social Worker:

53 year old African American male with HTN and heart condition. Lives alone in housing from which he may be forced to move due to increased rent. Clt currently working with housing assistance to obtain new housing.

Important Information for Physician

Special Notes/Comments for Physician:

MD documentation reports cardiomyopathy (EF - 46%), hypertension, and hyperlipidemia. Clt was hospitalized most recently three months ago for condition. Clt reports being under MD orders to not work. Clt c/o shortness of breath, inability to take care of all ADLs without son's assistance.

PHQ-9 Score Total: **Depression Severity:** None

Proposed Treatment Actions: None

Medical History of Applicant/Participant

Top

Physician's View

Current Medical Conditions Related to Employment As Described by Applicant/Participant:

HTN HLD SOB HEART CONDITION

Other Current Medical Conditions As Described By Applicant/Participant:

--

Current Treating Health Care Provider:

GIVEN DR PERRYS CLINIC
CARD FOR PCP/EM

Complying With Treatment: --

Current Medications:

Medication	Dosage	Frequency
LIPITOR	81MG ASA	HCTZ
METOPROLOLOL	NITRO	

Allergic to Medication:

Medication	Reaction
LASIX	EDEMA

Other Allergies: --

Family History/Genetic Diseases: Cardiovascular Disease; Hyperlipidemia; Hypertension;

History of Tobacco Use? Yes **How Long?** 10+ Years **When Last Used?** Current Smoker **Packs/Day?** Under 1

Hospitalizations, Surgeries, Major Illnesses:

Problem:	How Long Ago?	How Long in Hospital?
Hypertension	Last Year	1-7 Days
Angina	Last Year	1-7 Days

Other: --

HIV Status

HIV Consent Form Signed? Yes
HIV Status: Negative
History of Unprotected Sex or IV Drug Use? No
If HIV Positive, Treatment Being Received: --
If HIV Positive, Do You Have AIDS? --
If HIV Status Not Known, Would you like To Be Tested? No

For Female Only

How Many Times Pregnant? --
Are You Pregnant Now? --
If Pregnant, When Are You Due? --
How Many Children You Have Given Birth To? --
How Many Abortions or Miscarriages Have You Had? --
Comments:
--
(Completed 1/10/2007 By Dennis Deluca, Hospital QHP/OHT, Bronx Lebanon Hospital)

Vital Signs: **T** 98.1 **P** 72 **R** 17 **BP** 143 / 106 **Height** 67 **Weight** 196 **BMI** 30.69
(Completed 1/11/2007 By Dennis Deluca, Hospital QHP/OHT, Bronx Lebanon Hospital)

Top

Vision Exam

Physician's View

Left
Vision Without Corrective Lenses --
Vision With Corrective Lenses READING
Right
Vision Without Corrective Lenses --
Vision With Corrective Lenses --

Standard Laboratory Tests Ordered

Client Fasted Yes
CBC, Chem-20, Lipid Profile, Urinanalysis Order Date 01/10/2007
EKG Order/Results Date 01/10/2007
Results --

Additional On-Site Diagnostic Tests

PFT Order/Results Date --
Results --

Pulse Oximeter Order/Results Date 01/10/2007
Results 100

Standard Laboratory Test Results

Results Date 01/11/2007
Clinically Normal Labs:" Yes

Test
Positive Results

Additional Diagnostic Tests Ordered

Test: **Order Date:** **Ordered for Specialty:**

Additional Laboratory Tests Ordered

Test: **Order Date:** **Ordered for Specialty:**

Additional Diagnostic Test Results

Test: **Result Date:** **Positive Results:**

Additional Laboratory Test Results

Test: **Result Date:** **Positive Results:**

Comments --
(Completed 1/11/2007 By Dennis Deluca, Hospital QHP/OHT, Bronx Lebanon Hospital)

Medical Examination - Review of System

General	Normal	**Skin**	Normal	**Head**	Normal
Eyes	Normal	**Ears**	Normal	**Nose**	Normal
Mouth/Throat	Normal	**Neck**	Normal	**Breasts**	Normal
Respiratory	Normal	**Cardiovascular**	See Below	**Gastrointestinal**	Normal
Genitourinary	Normal	**Reproductive - Males**	Normal	**Reproductive - Females**	N/A
Menstrual History	N/A	**Obstetric History**	N/A	**Endocrine**	Normal
Musculoskeletal	Normal	**Hematopoietic**	Normal	**Neurologic**	Normal
Emotional/Psychiatric	Normal				

System	Findings	Comment
Cardiovascular	Chest Pain	hypertension/ hyperlipidemia/ cardiomyoapthy with low ef.
Cardiovascular	Dyspnea on Exertion	--

Comments: --
(Completed 1/10/2007 By M. Shuja, Hospital Physician - Phase I, Bronx Lebanon Hospital)

Medical Examination - Physical Examination

Constitutional	Normal	**Head**	Normal	**Eyes**	Normal
Nose	Normal	**Mouth**	Normal	**Throat**	Normal
Neck	Normal	**Lymph Nodes: Neck**	Normal	**Chest**	Normal

Respiratory	See Below	**Cardiovascular**	See Below	**Pulses**	Normal
Gastrointestinal	Normal	**Male Genito-Urinary**	N/A	**Female Genitourinary Female Pelvic Exam**	N/A
Breast	N/A	**Skin**	Normal	**Extremities - Musculoskeletal**	Normal
Neurological/Psychiatric	Normal	**Neurological/Cranial Nerves Intact**	Normal	**Motor System**	Normal
Sensation	Normal	**Cerebellar**	Normal	**Reflexes Normal**	Normal

System	Abnormal Findings/Comments
Respiratory	bibasilr crackles heard.
Cardiovascular	no s3 and s4 on exam. no gallop or murmur heard.

Comments:

--

(Completed 1/13/2007 By M. Shuja, Hospital Physician - Phase I, Bronx Lebanon Hospital)

Pain Assessment

Any Pain? Not Applicable

Location of Pain: --

The Number That Best Describes The Patient's Level of Pain:

Present Pain: --

Worst Pain Gets: --

Best Pain Gets: --

Acceptable Level of Pain: --

(Completed 1/10/2007 By M. Shuja, Hospital Physician - Phase I, Bronx Lebanon Hospital)

Work Limitations Criteria

Deferred Until BPS Phase II Exam(s) Completed: No

Status: Phase I Preliminary Restrictions

Any Restriction: Yes

Number of Hours Patient Can Consistently Perform Specified Activity in 8 Hour Period

Sitting: -- **Standing:** -- **Walking:** --

Pulling: -- **Climbing:** -- **Bending:** --

Kneeling: -- **Reaching:** -- **Grasping:** --

Weight Handling Frequencies - Lifting,Carrying,Pushing - Times Per Hour

Total Number of Hours Patient Can Perform Weight Handling Frequencies During An 8 Hour Work Period

Lifting	Carrying	Pushing
Less Than 10 Pounds: --	**Less Than 10 Pounds:** --	**Less Than 10 Pounds:** --
10-20 Pounds: --	**10-20 Pounds:** --	**10-20 Pounds:** --
20-50 Pounds: --	**20-50 Pounds:** --	**20-50 Pounds:** --
50+ Pounds: --	**50+ Pounds:** --	**50+ Pounds:** --

Environmental Restriction: --

Additional Restriction: --

Comments: --

Status: Phase I Final Restrictions

Any Restriction: Yes

1800

ADVOCATE for Injured Workers

New York State Workers' Compensation Board

20 Park St.
Albany, NY 12207
www.WCB.State.NY.US
1-800-580-6665

REMEMBER: SAFETY FIRST

THE "BEST" ACCIDENT
IS THE ONE
THAT NEVER HAPPENS

For information about your workers' compensation claim, contact:
Advocate for Injured Workers
1-800-580-6665
20 Park Street
Albany, NY 12207

www.WCB.State.NY.US

Directory of Board Services

Customer Service
1.877.632.4996

Advocate for Business
1.800.580.6665

Health Care Provider
1.800.781.2362

Administrative Review Division
1.877.258.3441

Fraud Referral Hotline
1.888.363.6001

Disability Benefits
1.800.353.3092

Bureau of Compliance
1.866.298.7830

Directory of Board Offices

Albany District Office
100 Broadway - Menands
Albany, NY 12241
1.866.750.5157

Binghamton District Office
State Office Bldg., 44 Hawley Street
Binghamton, NY 13901
1.866.802.3604

Brooklyn District Office
111 Livingston Street
Brooklyn, NY 11201
1.800.877.1373

Buffalo District Office
Cyclorama Building
369 Franklin Avenue
Buffalo, NY 14202
1.866.211.0645

Hauppauge District Office
220 Rabro Drive, Suite 100
Hauppauge, NY 11788-4230
1.866.681.5354

Hempstead District Office
175 Fulton Avenue
Hempstead, NY 11550
1.866.805.3630

Manhattan District Office
215 W. 125th Street
New York, NY 10027
1.800.877.1373

Peekskill District Office
41 North Division Street
Peekskill, NY 10566
1.866.746.0552

Queens District Office
168-46 91st Avenue
Jamaica, NY 11432
1.800.877.1373

Rochester District Office
130 Main Street West
Rochester, NY 14614
1.866.211.0644

Syracuse District Office
935 James Street
Syracuse, NY 13203
1.866.802.3730

The Office of the Advocate for Injured Workers was created as a unique service to assist workers who were injured or made ill on their job in New York State. The Advocate staff provides guidance and information to injured workers to enable them to protect their rights in the workers' compensation system.

If you're unsure of your rights as an injured worker, help is just a phone call away, and it is free. Just call 1-800-580-6665. The staff in the Advocate's office can give you straight answers about:

- **How to File a Claim**
- **What Forms are Used**
- **Who is Covered**
- **Controverted Claims**
- **Hearing and Appeal Rights**
- **Timely Filing**
- **Record Keeping**
- **Your Role in Your Medical Treatment**
- **What Medical Benefits are Available**
- **Rehabilitation and Social Work**

Workers' compensation fraud is a Class E felony, punishable with up to four years imprisonment, $5000 individual/$10,000 corporate fine, and five years probation. Subsequent violations are a Class D felony.

When calling the Advocate for Injured Workers, please have this information available:

- **Claimant's Name**
- **Claimant's Case Number**
- **Area Code & Telephone Number**
- **Brief Description of the Problem and Any Correspondence Received**

The Advocate for Injured Workers travels throughout the state meeting with labor unions, employers, Committee for Occupational Safety and Health groups, and injured workers support groups to update them on changes within the workers' compensation system.

IF YOU ARE INJURED ON THE JOB

- **Seek first-aid or other necessary medical treatment as soon as possible.**
- **Report the injury to your employer in writing within 30 days after the date of the accident.**

(In the case of an occupational disease, notification should be given within two years after disablement, or within two years after the claimant knew or should have known that the disease was work-related, whichever is later.)

- **Complete a claim for workers' compensation on Form C-3 and mail it to the nearest office of the Workers' Compensation Board.**

(If a claim is not filed within two years from the date of the injury or disablement from occupational disease, an injured or disabled worker may lose his or her right to benefits.)

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157
State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604
369 Franklin Street BUFFALO 14202 (866) 211-0645
130 Main Street W. ROCHESTER 14614 (866) 211-0644
935 James St. SYRACUSE 13203 (866) 802-3730

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ☐WCB ☐DB ☐Discrimination and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:
Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, Benjamin Holmes (Claimant's Name) represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to _____ (Name of a Specific Person, Corporation, Association or Public or Private Entity), at P.O. Box 764 Bronx N.Y. 10469 (Address).

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

Benjamin Holmes 5/31/10
Claimant's Signature (ink only -- use blue ballpoint pen if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205

100 Broadway
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ALBANY 12241

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BINGHAMTON 13901

369 Franklin Street
BUFFALO 14202

130 Main Street W.
ROCHESTER 14614

935 James Street
SYRACUSE 13203

COVER SHEET - REBUTTAL OF APPLICATION FOR BOARD REVIEW

☐ Check here if this Rebuttal was faxed to the Board's centralized fax line 877-533-0337. (See Subject No. 046-144 for instructions.)

WCB Case Number(s)	Carrier Case Number(s)	Carrier Code	Carrier's Name	Date of Injury

Claimant's Name	Address

TO THE SENDER: If this Rebuttal was not FAXED to the Board's centralized fax line as indicated above, then the original of this form and any attachments MUST BE MAILED to the address listed above. Supply all information requested. Failure to do so may cause this rebuttal to be deemed defective. Attach additional sheets only when there is not enough room to supply the information on this form. A copy of this Rebuttal and any attachments MUST be served upon ALL parties in interest. Complete the Affidavit or Affirmation of Service on the reverse side of this form.

1. This rebuttal is made on behalf of:
   ☐ Claimant ☐ Employer/Carrier _____ (name) ☐ Special Funds ☐ Uninsured Employers' Fund

2. This rebuttal is in response to an application for: (choose only one)
   ☐ Review of WCLJ Decision (WCL § 23 and 12 NYCRR 300.13)
   ☐ Rehearing or Reopening (12 NYCRR 300.14)

3. The application was served upon the above cited party on: _____

4. The filing date of the decision which is the subject of the application is: _____

5. This rebuttal contends that the:
   ☐ Application should be denied under 12 NYCRR 300.13(e).
   ☐ Decision should be administratively corrected to read: _____
   ☐ Decision should be affirmed in its entirety
   ☐ Decision should be modified as to: _____

6. As to the finding(s) of fact and/or conclusion(s) of law made in the decision, this rebuttal contends:
   _____
   _____
   _____
   _____
   _____

7. Does the record cited in the application constitute the full record for review?: ☐ Yes ☐ No
   If Yes, do you rest on that record?: ☐ Yes ☐ No
   If No, and you contend that the record cited in the application does **not** constitute the full record for review, provide below the additional hearings, documents, and transcripts in the WCB's electronic file that are relevant to the issue(s) and ground(s) raised in the application, were **not** cited on the application, and complete the record for review:

   Hearings: provide date(s) where issue(s) was raised before the Workers' Compensation Law Judge and evidence presented pertaining to the issue(s) and ground(s) raised and document ID number if applicable. If hearing minutes have not been transcribed, so indicate:
   _____
   _____
   _____
   _____

   Documents: provide name and document ID number:
   _____
   _____
   _____

WORKERS' COMPENSATION BOARD
Bureau of Compliance

ENFORCEMENT UNIT
INVESTIGATOR'S REPORT

Claimant: Holmes Benjamin	
Date Of Accident: 07/30/79	WCB#: 07925837
Alleged Employer:	

Investigation Request:
Investigation ensued pursuant to special request from Supervising Law Judge, Chaim Malks.
From: Chaim Malks/PEEK/WCB
03/23/2010 03:53 PM
To: Richard Regino
Subject Benjamin Holmes 07825837
This pro se claimant has a claim that is being controverted as untimely as the incident occurred in 1979. He insists that he filed a claim in 1980 and received an award in 1985. SIF has no record. The SIF rep believes that SIF was not the carrier. The Board has no electronic record of the alleged earlier claim. Is there anything else you can search?

Report of Investigation

Entity (include business address, and names and residence addresses of principals) : See investigation narrative below		
Employer #:	UIER #:	FEIN #:
Coverage: W Code:		
Other POI Entities:		
Other Coverage (Section 56, etc.):		
License / Permit Searches:		
Documents Submitted With This Report.: Copies of Accurint printouts from search engine		
District Office: Peekskill NY Investigator: Senior Investigator: Richard Regino/PEEK/WCB		● Final Report ○ Interim Report Date: 04/12/2010

Report Details (please indent paragraphs) :

Pursuant to request of Supervising Law Judge Chaim Malks , an investigation was ensued .
Reference WCB case #'s 07925837 & G0123585

Synopsis
On March 24, 2010 Sr Investigator Regino contacted the claimant via telephone and confirmed claimants identity and current mailing address (PO Box 764 Bronx NY)
Claimant advised as follows:
Benjamin Holmes (no middle initial or name) No aliases other then Ben/Benny.
Current physical residence: 3315 Radcliff Ave Bronx NY 10469 (will be moving shortly)
Claimant previously resided in a basement room at an undisclosed shelter.
Cell telephone 917 971 4738 (No land line available)

RECEIVED
APR 16 2010
WCB PEEKSKILL

Subject history
Original injury was alleged to have occurred at a gulf Gas Station located at 1101 Grenada Place Bronx NY 10466.
Alleged entity: L & L Gulf Gas Station (Owner/Partner Luis Leon & Leopold N Bonitto)
Garage demolished and allegedly replaced by 47th police precinct parking area.

C-49.2

Robert E. Beloten
Chair

ADMINISTRATIVE REVIEW DIVISION
WORKERS' COMPENSATION BOARD
328 STATE STREET
SCHENECTADY, NY 12305
www.wcb.ny.gov

no appeal

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

MEMORANDUM OF BOARD PANEL DECISION

keep for your records

Opinion By: David R. Dudley
Richard A. Bell
Linda Hull

The claimant's attorney requests review of the Workers' Compensation Law Judge (WCLJ) decision filed on December 3, 2012. The claimant has filed a pro se application for review. The self-insured employer, the City of New York (City), has filed a rebuttal.

ISSUES

The issues presented for administrative review are:

1. whether the claim is barred by Workers' Compensation Law (WCL) §18.

2. whether the claim is barred by WCL § 28.

FACTS

This is a controverted claim for chest pain. The claimant was employed by the City as a job training participant. The initially alleged date of injury was November 1, 2006.

In a C-3 form (Employee Claim for Compensation) filed on June 3, 2010, the claimant asserted that he had pain in his chest while working for New York City Parks and Recreation on

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	12/16/2013

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

November 1, 2006. On the form, the claimant indicated that his first treatment was on December 29, 2004.

The City filed a C-7 form (Notice that Right to Compensation is Controverted) contending that there was no accident and no medical evidence supporting a causal relationship. Further, the City raised the following issues: accident/occupational disease within the meaning of the WCL; accident/occupational disease arising out of and in the course of employment; notice (WCL § 18); and timely filing (WCL § 28).

The claimant filed a C-3 form on July 25, 2012, asserting that there was an injury on May 27, 2006 and that the claimant experienced chest pain.

At a hearing held on November 28, 2012, the claimant's attorney noted that, while the medical records in the file do not specifically reference an injury that occurred at work, the entire medical file should be accepted as prima facie medical evidence (PFME). The WCLJ found no PFME.

In a decision filed on December 3, 2012, the WCLJ disallowed the claim, finding that the claim is barred by WCL § 18 and WCL § 28.

LEGAL ANALYSIS

In the application for review, the claimant's attorney asserts that WCL § 28 was waived because an "advance compensation" was made by the claimant's employer prior to the expiration of the two year statute of limitations. The City paid wages in recognition of the claimant's injuries. The claimant's attorney contends that the claimant went home during the workday and notified the employer, and that the claimant was paid for the entire day. The claimant notes that he did not have an opportunity to testify on the issue of WCL § 28, and therefore the WCLJ's decision should be rescinded and the matter returned for further development of the record on the issue of WCL § 28.

The claimant filed a pro se application for review, dated December 26, 2012, on December 31, 2012. The claimant requests a hearing because his lawyer "did not know how to read the Doctor notation." The claimant indicates that he has information that he got sick on the job and is willing to provide the information to the WCLJ.

In rebuttal, the City contends that the application for review should be denied because it was not properly served on all parties on the same date. Further, the claimant has not appealed the

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	12/16/2013

ATENCION:

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disallowance of the claim under WCL § 18, and the City asserts that, since the claimant has not taken issue with the finding of WCL § 18, the appeal regarding WCL § 28 is moot. The City notes that the initial C-3 form alleged that the accident occurred on November 1, 2006, the revised C-3 form alleged that an accident occurred on May 27, 2006, and the claimant's medical indicates that the accident occurred in December 2006. The City asserts that, even using the date most favorable to the claimant, the C-3 form dated June 3, 2010 was filed nearly four years late. The claimant alleges an advanced payment of compensation as a defense for WCL § 28 for the first time on appeal, and it was never raised at any of the prior hearings. The City contends that the claimant waived the right to raise such a defense. The City has submitted timesheet records that show that the claimant did not miss any work on the alleged date of accident.

WCL § 18

"Workers' Compensation Law § 18 requires claimants seeking benefits to provide their employers with written notice of a compensable injury 'within thirty days after the accident causing such injury' (*see Matter of Miner v Cayuga Correctional Facility*, 14 AD3d 784 [2005]) ... Failure to provide such notice bars any claim, unless the Board excuses that failure on the ground that notice could not be given, the employer or its agent had knowledge of the accident, or the employer was not prejudiced (*see* Workers' Compensation Law § 18). The Board is not required to excuse a claimant's failure to give timely written notice even if one of these grounds is present, the matter lies within the Board's discretion" (*Matter of Dusharm v Green Is. Contr., LLC*, 68 AD3d 1402 [2009]). "Where ... the employer or its agent had oral notice was provided to the employer or to the employer's agent, '"resolution of the sufficiency of a claimant's oral notice is a matter within the exclusive province of the Board"' (*id. quoting Matter of Pisarek v Utica Cutlery*, 26 AD3d 619 [2006]). If a lack of prejudice to the employer is asserted, a claimant bears the burden of demonstrating that the employer was not prejudiced by any delay (*Matter of Flynn v Ace Hardware Corp.*, 38 AD3d at 1144; *see Matter of Miner v Cayuga Correctional Facility*, 14 AD3d at 785; *Matter of Dempster v United Parcel Serv.*, 280 AD2d at 723)" (*Matter of Ewool v Franklin Hosp. Med. Ctr.*, 43 AD3d 1019 [2008], *lv denied* 10 NY3d 711 [2008]).

In this case, the Board Panel notes that the claimant did not provide written notice within 30 days of the alleged accident. The Board Panel further finds that the claimant failed to demonstrate the applicability of any of the three grounds to excuse late notice under WCL § 18.

Therefore, the Board Panel finds, upon review of the record and based on a preponderance of the evidence, that the WCLJ appropriately found that the claim is barred by WCL § 18.

WCL § 28

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed. High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	12/16/2013

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

Pursuant to WCL § 28, a claim for compensation will be barred unless the claim is filed with the Board within two years of the accident date.

Under WCL § 28, remuneration or payments by an employer on account in the form of wages medical treatment, or other compensable [illegible] exception to the two-year claim-filing requirement, provided that the payments [illegible] recognition or acknowledgment of liability under the Workers' Compensation Law (*see Matter of Schneider v Dunkin Ice Cream*, 301 AD2d 906 [2003]). When payments are made without regard to the cause of injury, there can be no finding of advance payment (*see Matter of Kaschak v IBM Corp.*, 256 AD2d 830 [1998]).

In this case, the claim was filed more than four years late. The claimant raises an untimely payment of compensation as a defense to WCL § 28. The [illegible] show that the claimant did not miss any work on the alleged date of accident.

[illegible] payment of compensation to be [illegible] burden of showing that the employer made an advance payment of compensation in recognition of its liability for his injury at work. The claimant does not have sufficient evidence of the employer's advanced payment of compensation.

Therefore, the Board Panel finds, upon review of the record and based on a preponderance of the evidence, that the claimant has not met his burden of showing that the employer made an advanced payment of compensation; that the claim is barred by WCL § 28; and that the claim was properly disallowed.

CONCLUSION

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	12/16/2013

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

ACCORDINGLY, the WCLJ decision filed on December 3, 2012 is AFFIRMED. No further action is planned at this time.

All concur.

David R. Dudley

Richard A. Bell

Linda Hull

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	12/16/2013

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, por el numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

NOTICE OF PRE-HEARING CONFERENCE / HEARING

State of New York
WORKERS' COMPENSATION BOARD

PLACE OF CONFERENCE	Part	Date of Conference	Time	District Office
Workers Compensation Board 215 W. 125th Street, 4th Floor New York, NY 10027	21	09/19/2012	9:00 AM 15 Min	NYC (800) 877-1373
		WCB Case No.	Date of Accident	WCB Home Page
		G0477983	11/01/2006	www.wcb.ny.gov
			Carrier ID No.	Carrier Case No.
			W847008	

CLAIMANT
Benjamin Holmes

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

CLAIMANT: Bring this notice with you.

CLAIMANT, CLAIMANT'S REPRESENTATIVE (if applicable), INSURANCE CARRIER/ SELF-INSURED EMPLOYER:

Please read important information on the reverse side in addition to the information below.

EMPLOYER NYC Parks & Recreation

CARRIER City of New York
c/o NYC Law Dept

COPIES TO Benjamin Holmes
Joseph A. Romano Law Offices

The employer/carrier has objected to the claim for workers' compensation benefits by filing a Notice of Controversy (Form C-7). Because the employer/carrier objected to the claim, the claimant is not receiving any benefits. As compensation benefits are not being paid, the Board has scheduled a Pre-Hearing Conference with the parties.

The purpose of the Pre-Hearing Conference is to provide a mechanism for the identification of issues and relevant evidence and to permit the parties an opportunity to assess their case and to resolve outstanding issues prior to trial.

Ten days prior to the Pre-Hearing Conference, each party shall file with the Board a Pre-Hearing Conference Statement (Form PH-16.2). The parties should also bring two additional copies to the Pre-Hearing Conference. In cases where the claimant is not represented by counsel at the Pre-Hearing Conference, the claimant is not required to file the Pre-Hearing Conference Statement. If the claimant retains a legal representative within 10 days of the Pre-Hearing Conference, a Pre-Hearing Conference Statement must still be filed.

The claimant's and employer/carrier's statement shall be accompanied by any and all reports, forms and documents that the claimant or employer/carrier intends to use at the hearing(s), including hospital records and forms detailing the employer's statement of wages and the claimant's work status, except if the reports, forms or documents are already part of the Board's electronic case folder.

For claimants represented by counsel, an employee claim form (Form C-3) shall be accompanied by an attorney certification. Employers/carriers, or their legal representative, must file a written certification when the notice of controversy (C-7) is filed.

If as a result of the Pre-Hearing Conference an Initial Expedited Hearing is scheduled, any Independent Medical Examination (IME) Report shall be filed with the Board at least three days before the date set for the Initial Expedited Hearing. Failure to file and serve an IME Report shall be a waiver of the insurance carrier's right to examine the claimant and to have the IME Report considered on the threshold issue of causal relationship, unless the employer/carrier makes a showing of good cause for such failure, and that it acted in good faith and with due diligence.

Forms may be located at the Board's web site or by calling the nearest District office. Claimants who represent themselves may call the Advocate for Injured Workers at 1-800-580-6665 if they have questions about completing the forms.

THE NEW YORK STATE WORKERS' COMPENSATION BOARD PROHIBITS VISITORS, EMPLOYEES, CLIENTS OR WITNESSES FROM CARRYING OR BEARING FIREARMS OR ANY OTHER WEAPON ON BOARD PREMISES.

Dated: 08/30/2012

(266)417~~18457~~-16 (11/08)

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov
(800) 877-1373

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 09/19/2012 involving the claim of Benjamin Holmes at the Manhattan hearing location, Judge William Dugan made the following decision, findings and directions:

DECISION: Issues in controversy (C-7 issues) have been raised by the carrier/employer.

Claimant did not appear at the hearing, or was otherwise not prepared to proceed - ~~I was there~~ 30 minent late there is no medical in the file.

. The case is continued to address the following issue(s): Accident Within Meaning Of Workers' Compensation Law, Accident Arising Out Of And In The Course Of Employment, Occupational Disease Within Meaning Of Workers' Compensation Law, Occupational Disease Arising Out Of And In The Course Of Employment, Notice (Section 18), Timely Filing (Section 28). This case is not subject to the expedited hearing process and penalties.

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of New York
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	09/24/2012

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

EC-23 (4/98)

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov

(800) 877-1373

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 10/10/2012 involving the claim of Benjamin Holmes at the Manhattan hearing location, Judge William Dugan made the following decision, findings and directions:

DECISION: Issues in controversy (C-7 issues) have been raised by the carrier/employer.
Claimant asks for the opportunity to review the medical reports in physical evidence for prima facie medical evidence.

City raises C-7 including Sections 18 and 28.

C-3s filed by claimant differ on many points.
. The case is continued to address the following issue(s): Accident Within Meaning Of Workers' Compensation Law, Accident Arising Out Of And In The Course Of Employment, Occupational Disease Within Meaning Of Workers' Compensation Law, Occupational Disease Arising Out Of And In The Course Of Employment, Notice (Section 18), Timely Filing (Section 28). This case is not subject to the expedited hearing process and penalties.

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of New York
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	10/15/2012

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205

100 Broadway Menands ALBANY 12241 | State Office Building 44 Hawley Street BINGHAMTON 13901 | 295 Main Street Suite 400 BUFFALO 14203 | 130 Main Street W. ROCHESTER 14614 | 935 James Street SYRACUSE 13203

COVER SHEET - APPLICATION FOR BOARD REVIEW

WCB Case Number(s)	Carrier Case Number(s)	Carrier Code	Carrier's Name	Date of Injury
G0477983	W847008	0846-12-02699	City of New York N.Y.C.	11/01/2006

Claimant's Name	Address
Benjamin Holmes	P. O. Box 764 Bronx N.Y 10469

TO THE APPLICANT: This Application for Board Review may be filed with the Board by fax (1-877-533-0337; see Subject No. 046-144), e-mail (wcbclaimsfiling@wcb.ny.gov); see Subject Nos. 046-144 and 046-375), personal delivery to a Board District Office, or by mailing to one of the Board addresses listed at the top of this page. A copy of this Application must be served on all parties in interest. Sections 1 and 2 on the reverse side of this form must be completed. The failure to supply all information requested by this form may result in dismissal of the Application. If an additional attorney fee is being requested, Form OC-400.1 must be attached and served on all parties. For Applications filed by a carrier, TPA or self-insured employer, an up-to-date Form C-8/8.6 must be attached and served on all parties.

TO ALL OTHER PARTIES: Any Rebuttal to this Application must be served on the Board within 30 days following the date on which the Application was served on the parties, as specified in Section 2 on the reverse side of this form.

1. This application is made on behalf of:
☒ Claimant ☐ Employer/Carrier Benjamin Holmes (name) ☐ Special Funds ☒ Uninsured Employers' Fund
☐ Attorney/Licensed Representative

2. This application is made for: (choose only one)
☒ Review of WCLJ Decision (WCL § 23 and 12 NYCRR 300.13)
☒ Rehearing or Reopening (12 NYCRR 300.14)

3. The filing date of the decision which is the subject of this application is: 11/28/2012 Juge William Dugan

4. The remedy sought is:
☒ Administrative Correction of Decision ☐ Modification of the Decision
☐ Reversal of the Decision ☐ Rescission of the Decision

5. This application arises from an expedited hearing: ☒ Yes ☐ No

6. Specify the issue(s) for review:

☐ Employer/employee relationship	☐ Average Weekly Wage	☐ Special Funds Liability
☐ Accident	☒ Authorization of Treatment	☐ Attorney/Licensed Representative Fee
☐ Occupational Disease	☒ Period of Disability	☐ Facial Award
☐ Notice	☐ Degree of Disability	☐ Section 32 Denial
☐ Causal Relationship	☐ Reimbursement	☒ Disability Benefits
☐ Death Benefits	☒ Penalty	☐ Discrimination
☐ Timely Claim Filing	☐ WCL § 114-a Disqualification	☐ Policy Coverage
☐ Jurisdiction	☒ Apportionment	☐ ATF Deposit

7. Specify the grounds for review (foundation, basis, or points) relied upon in raising the issues identified above.
To whoit my Concearn I Benjamin Holmes asking For a hearing because of my lawer did not know How to Read the Doctor notation I went to the Montefiore Hospital to highlight all of the information I have all of that information that I got sick on the Job this is why I ame asking For a hearing I ame willen to Provide this information to the Juge.

8. Make reference to the record below, or such part thereof, as is relevant to the issue(s) and ground(s) raised in this application. Also, indicate when and where such issue(s) and ground(s) were raised before the Workers' Compensation Law Judge.

Hearings (if minutes are not transcribed, so indicate):

Documents: provide name and document ID number:

State of New York
WORKERS' COMPENSATION BOARD

(268)41304497-1

NOTICE OF PRE-HEARING CONFERENCE / HEARING

PLACE OF CONFERENCE	Part	Date of Conference	Time	District Office
Workers Compensation Board 215 W. 125th Street, 4th Floor New York, NY 10027	21	07/09/2012	9:30 AM 15 Min	NYC (800) 877-1373
		WCB Case No.	Date of Accident	WCB Home Page
		G0477983	11/01/2006	www.wcb.ny.gov
			Carrier ID No.	Carrier Case No.
			W847008	

CLAIMANT
Benjamin Holmes

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

CLAIMANT: Bring this notice with you.

CLAIMANT, CLAIMANT'S REPRESENTATIVE (if applicable), INSURANCE CARRIER/ SELF-INSURED EMPLOYER:

Please read important information on the reverse side in addition to the information below.

EMPLOYER NYC Parks & Recreation

CARRIER City of New York
c/o NYC Law Dept

COPIES TO Benjamin Holmes

The employer/carrier has objected to the claim for workers' compensation benefits by filing a Notice of Controversy (Form C-7). Because the employer/carrier objected to the claim, the claimant is not receiving any benefits. As compensation benefits are not being paid, the Board has scheduled a Pre-Hearing Conference with the parties.

The purpose of the Pre-Hearing Conference is to provide a mechanism for the identification of issues and relevant evidence and to permit the parties an opportunity to assess their case and to resolve outstanding issues prior to trial.

Ten days prior to the Pre-Hearing Conference, each party shall file with the Board a Pre-Hearing Conference Statement (Form PH-16.2). The parties should also bring two additional copies to the Pre-Hearing Conference. In cases where the claimant is not represented by counsel at the Pre-Hearing Conference, the claimant is not required to file the Pre-Hearing Conference Statement. If the claimant retains a legal representative within 10 days of the Pre-Hearing Conference, a Pre-Hearing Conference Statement must still be filed.

The claimant's and employer/carrier's statement shall be accompanied by any and all reports, forms and documents that the claimant or employer/carrier intends to use at the hearing(s), including hospital records and forms detailing the employer's statement of wages and the claimant's work status, except if the reports, forms or documents are already part of the Board's electronic case folder.

For claimants represented by counsel, an employee claim form (Form C-3) shall be accompanied by an attorney certification. Employers/carriers, or their legal representative, must file a written certification when the notice of controversy (C-7) is filed.

If as a result of the Pre-Hearing Conference an Initial Expedited Hearing is scheduled, any Independent Medical Examination (IME) Report shall be filed with the Board at least three days before the date set for the Initial Expedited Hearing. Failure to file and serve an IME Report shall be a waiver of the insurance carrier's right to examine the claimant and to have the IME Report considered on the threshold issue of causal relationship, unless the employer/carrier makes a showing of good cause for such failure, and that it acted in good faith and with due diligence.

Forms may be located at the Board's web site or by calling the nearest District office. Claimants who represent themselves may call the Advocate for Injured Workers at 1-800-580-6665 if they have questions about completing the forms.

THE NEW YORK STATE WORKERS' COMPENSATION BOARD PROHIBITS VISITORS, EMPLOYEES, CLIENTS OR WITNESSES FROM CARRYING OR BEARING FIREARMS OR ANY OTHER WEAPON ON BOARD PREMISES.

Dated: 06/21/2012

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

Robert E. Beloten
Chair

ADMINISTRATIVE REVIEW DIVISION
WORKERS' COMPENSATION BOARD
328 STATE STREET
SCHENECTADY, NY 12305
www.wcb.ny.gov

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

MEMORANDUM OF BOARD PANEL DECISION

keep for your records

Opinion By: David R. Dudley
Richard A. Bell
Linda Hull

The claimant's attorney requests review of the Workers' Compensation Law Judge (WCLJ) decision filed on December 3, 2012. The claimant has filed a pro se application for review. The self-insured employer, the City of New York (City), has filed a rebuttal.

ISSUES

The issues presented for administrative review are:

1. whether the claim is barred by Workers' Compensation Law (WCL) §18.

2. whether the claim is barred by WCL § 28.

FACTS

This is a controverted claim for chest pain. The claimant was employed by the City as a job training participant. The initially alleged date of injury was November 1, 2006.

In a C-3 form (Employee Claim for Compensation) filed on June 3, 2010, the claimant asserted that he had pain in his chest while working for New York City Parks and Recreation on

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision–	12/16/2013

ATENCION:
Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

NYS Workers' Compensation Board
Licensed Claimants' Representatives
Section 24-a of the Workers' Compensation Law

Name/Address	Phone #
Baerga, Teresa c/o Feldstein & Baerga 26 Court Street - Suite 1213 Brooklyn, NY 11242	718-852-6238
Ben-Yosef, Eitan 383 Grand Street New York, NY 10002	212-505-7687
Blasko, Stacie L. c/o McGillicuddy & Siegel, P.C. 233 Broadway Newburgh, NY 12550	845-220-2667
Boardway, Jay P. 147 Linwood Avenue Buffalo, NY 14209	716-854-1446
Bottoni, Scott c/o Saurers & Sackel, LLP 81 Buffalo Street Hamburg, NY 14075	716-648-1300
Brook, Marilyn Servetah c/o Brook & Franz 20 Vesey Street - Suite 401 New York, NY 10007	212-233-0710
Burman, Mark R. 214-11 Northern Boulevard, Suite 201 Bayside, NY 11361	718-464-9490
Cerle, William R. c/o Ouimette, Goldstein & Andrews, P.C. 88 Market Street - P. O. Box 192 Poughkeepsie, NY 12602	914-567-0100
Chisholm, James A. c/o Law Office of Ralph Kirk Nine Main Street P. O. Box 4466 Kingston, NY 12402	845-338-4477
Cohen, Steve 225 Broadway Suite 1505 New York City, NY 10007	732-492-8619

MONTEFIORE
Moses Emergency Department
111 East 210th Street
Bronx, NY 10467
718.920.5731

Patient: HOLMES, Benjamin
DOB: 04/19/1953 Sex: Male
Age: 55 - 75 yr
Med Rec# 01287053
Account# 179688759

PATIENT DISCHARGE INSTRUCTIONS

Our doctors and staff appreciate your choosing us for your emergency medical care needs. Read these aftercare instructions carefully. Please call us if you have any questions about your medical problem. We are here to serve you.

CHEST PAIN - NONSPECIFIC

Your exam has not identified a specific cause for your chest pain. This type of pain, however, is not usually due to serious heart or lung problems. Most often chest pain of this nature is caused by minor injuries, muscle strains, inflammation of the chest wall tissues, or indigestion. Drugs, alcohol, hyperventilation, and emotional upsets can make this kind of pain worse. Most of the time this type of chest pain will be much improved within 2-3 days.

Get plenty of rest for the next few days and avoid any activity that brings on the pain. Please do not smoke or drink alcohol until all your symptoms are completely better. Please call your doctor for routine follow-up as advised. You must see your doctor or go to the emergency room right away, however, if you have:

* Increased pain, or pain that radiates to the arm, neck, or abdomen.
* Shortness of breath, increasing cough, or coughing up blood.
* Severe weakness, fainting, fever, or chills.
* Severe back or abdominal pain, nausea, or vomiting.

PRESCRIPTIONS

Fill all the prescriptions ordered by your doctor and take them as directed. Generic medicines are as good as brand names, and often less expensive.

* If you have been given an antibiotic, be sure to take all of it.
* Keep your drugs out of the reach of children, in a cool, dry, dark place.
* Don't give your medicine to other people or use it for other illnesses.
* Stop your medicine and call us right away if you have drug allergy symptoms or bad side-effects. Call also if you vomit or cannot swallow the medicine.
* Bring your medicines with you any time you go to emergency for treatment.

Ask your doctor or pharmacist about drug or food interactions that may be important to know about when taking your prescription or herbal medicines.

FOLLOW-UP CARE

Your physician today has been DR. Iwona REISS, MD
For follow-up care you have been referred to the following doctor or clinic:

Please make an appointment for further treatment as needed or in ___ days. Tell your referral doctor or clinic that we have sent you, and bring your medicines and instructions to the office. If you had x-rays, an EKG, or lab tests today, they have been reviewed by your doctor. We will contact you at once if other important findings are noted after further review by our staff. If you do not continue to improve or if your condition worsens, please call your doctor or the emergency department right away so you can be examined.

I acknowledge receipt of these instructions. I understand that my condition may require more care and will arrange for further treatment as recommended.

Benjamin Holmes

762 East 211 Street
Bronx, NY 10467
Mobile: (646) 335-8505

Objective: To obtain a challenging position with a company that will allow me to develop my skills and experience.

Experience:

City of New York Parks & Recreation — Bronx, NY — 06/06 - Present

Maintenance

- Clean parks, playgrounds, and surrounding areas
- Sanitize comfort stations and replenish supplies
- Paint benches remove graffiti from walls, playground equipment, and comfort stations; prepare debris for removal; flag hazardous material for pick up
- Sweep, rake, and collect leaves and debris
- Operate leaf blower, lawn mower, and weed whacker to beautify parks
- Provide park patrons with directions and answer questions about parks activities
- Report all safety hazards directly to supervisor

Self-Employed — Bronx, NY — 09/90 - 05/06

Auto Mechanic

- Repaired and overhauled automobiles, buses, trucks, and other automotive vehicles
- Examined vehicles and discussed with customers the nature and extent of damage or malfunction
- Removed unit, such as engine, transmission, and differential, using wrenches and hoist
- Disassembled unit and inspected parts for wear, using micrometer, calipers and thickness gauges
- Repaired or replaced carburetors, blowers, generators, distributors, starters, and pumps
- Re-lined and adjusted brakes and aligned front end
- Repaired or replaced shock absorbers and soldered leaks in radiators
- Replaced and adjusted headlights and installed and repaired accessories, such as radios, heaters, mirrors, and windshield wipers

NYC Parks Department — Bronx, NY — 06/93 - 09/02

Pool Attendant

- Monitored pools to prevent illegal entrance to facility and safeguarded trespasser against an accident
- Removed leaves and other debris from surface of water with net

Education:

George Washington High School — New York, NY

General Academic Studies

Auto Repair Workshop

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov
(877) 632-4996

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF PROPOSED DECISION

keep for your records

This decision makes legal findings about your on-the-job injury. It was made based on information in the Board's file as of this date.

The Findings section of this decision may state information such as what part of your body was injured; how much you were earning before you got hurt; how long you were out of work; whether you were entitled to be paid compensation benefits while you were out of work; the amount of weekly workers' compensation benefits; and if you have approval for medical treatment.

These legal findings are important and may limit your claim for workers' compensation benefits. If you DISAGREE with any part of this decision you must OBJECT. Write your objection on the back of this form and return it to the address listed above. The proposed decision will become FINAL on 8th day of July, 2014 so ANY OBJECTION to it must be RECEIVED by the Board BEFORE that date to be considered timely. Objections received on or after that date, will not be considered.

If you DO NOT UNDERSTAND this decision, you may contact the Board at 1-877-632-4996 for further information.

If you are not represented by legal counsel, you may want to consult an attorney or a licensed representative to assist you with your claim. An attorney or a licensed representative cannot charge you directly for representation in a workers' compensation case. If there is an award in your case, any legal fee request must be approved by the Board and will be deducted from the award to you by the insurance carrier and paid directly to the attorney or the licensed representative.

PROPOSED DECISION

FINDINGS: Form(s) C-8.1 which raised issues relating to treatment and/or disputed medical bills are resolved in favor of the carrier C-8.1B dated 3/21/14. Claim disallowed.

No further action is planned by the Board at this time.

*** *Continued on next page* ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	06/03/2014

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

Transcripts: provide date and document ID number:

_____

_____

Non-Scanable Evidence or Videotape (WMV or AVI format only): provide description:

_____

_____

List the following period(s) and/or medical benefits awarded which will be withheld pending this application:

_____

_____

). A Form OC-400.1 for an increased attorney's fee that has been properly served has been included with this application for consideration by the Board.

☐ Yes ☐ No

ertification: By signing this document in the space provided below, I certify that this application has a good faith basis in law and fact, has been instituted ith reasonable grounds, and has been served upon all parties at the addresses listed in the affirmation or affidavit of service below. I understand that the 'orkers' Compensation Law provides for substantial penalties for instituting or continuing proceedings without reasonable grounds and/or for the purpose of elay. I understand that if this application is withdrawn for any reason or if any of the issues raised are resolved by the parties, I must immediately notify the oard and the parties served in writing.

Signature of Person Preparing Form Benjamin Holmes Date 12/24/2012

Print Name Benjamin Holmes Title _____ Phone Number (347 313-6258

Address P.O. Box 764 Bronx NY 10469

ECTION 1

AFFIRMATION

TATE OF NEW YORK, COUNTY OF N.Y. ss: I, the undersigned, am an attorney duly admitted to the practice of law in the courts of the tate of New York. I hereby certify that I have complied with the filing and service requirements for this Application for Board Review in the manner escribed in Section 2 below.

affirm that the foregoing statements are true under penalties of perjury.

ated 12/24/2012 Signature Benjamin Holmes

Signer's Name (Print) Benjamin Holmes

AFFIDAVIT

STATE OF NEW YORK, COUNTY OF 3996 ss: I, Benjamin Holmes, being duly sworn, ay: I am over 18 years of age. I hereby certify that I have complied with the filing and service requirements for this Application for Board Review in the anner described in Section 2 below.

Sworn to before me on 12/26/2012 Signature Benjamin Holmes

Lydia E. Cruz Signer's Name (Print) Benjamin Holmes

Notary Public

Lydia E. Cruz
Commissioner of Deeds
City of New York No. 3-7319
Certificate Filed in Bronx County
Commission Expires May 01, 2014

ECTION 2

. Method by which Application was Filed with the Board (Check One):

☐ Fax (1-877-533-0337) ☐ E-Mail (wcbclaimsfiling@wcb.ny.gov) ☐ Mail (specify date below) ☐ Personal Delivery (specify date below)

Date of Mailing: _____ Date of Personal Delivery: _____

. Method of Service on the Parties (Check One): ☒ Mail ☐ Personal Delivery

Specify Date of Mailing or Personal Delivery _____

. Names and addresses of all Parties Served: (Attach additional sheets if necessary.)

NYC Health
Correctional Health Services

REFERRAL
Consultation Request and Hospital Transfer Form

Specialty:	
Provider Name:	Internal (REF) DOC
Facility:	George R. Vierno Center

Patient:	BENJAMIN HOLMES
DOB:	04/04/1953
Book and Case:	3491201829
NYSID:	03914346K
Facility:	George R. Vierno Center
Housing Area:	17B
MRN No:	

Referral From Information:

Provider Name:	David Kerrison, MD
Date and Time:	05/05/2012
Priority:	Routine
Diagnosis:	
Reason:	Please be advised that patient has medical reasons that may activate the magnometer.
Notes:	

Consulting Physician Information:

Date of Service: 5/5/12

Physician(Print Name): KERRISON MD Physician Signature:

Please place findings and recommendations below (use additional paper if necessary):

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205
www.wcb.ny.gov

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

ROBERT E. BELOTEN
CHAIR

Benjamin Holmes
PO Box 764
Bronx, NY 10469

October 17, 2013

In response to the claimant:
In the phone call of 10/15/2013 you indicated that you were inquiring as to the status of your appeal filed on 12/26/12.

Based upon your request:
This case has been referred to our Administrative Review Division for consideration of your application and you will be advised when a decision is rendered.

Workers' Compensation Board

Administrative Review Division
(877)632-4996

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	G0477983	Carrier ID No.:	W847008
Date of Accident:	11/01/2006	Carrier Case No.:	0846-12-02699
Employer:	NYC Parks & Recreation	Insurance Carrier:	City of NY Other Than Ed, High Ed, Water Sup, Hlth & Hospital

Transcripts: provide date and document ID number:

Non-Scanable Evidence or Videotape (WMV or AVI format only): provide description:

9. Has or will an appeal to the Memorandum of Decision be taken to the Appellate Division of the Supreme Court, Third Department? ☑ Yes ☐ No

Certification: By signing this document in the space provided below, I certify that this application has a good faith basis in law and fact, has been instituted with reasonable grounds, and has been served upon all parties at the addresses listed in the affirmation or affidavit of service below. I understand that the Workers' Compensation Law provides for substantial penalties for instituting or continuing proceedings without reasonable grounds and/or for the purpose of delay. I understand that if this application is withdrawn for any reason or if any of the issues raised are resolved by the parties, I must immediately notify the Board and the parties served in writing.

Signature of Person Preparing Form Benjamin Holmes Date ___/___/___

Print Name Benjamin Holmes Title _____ Phone Number (347) 313-6684

Address P.O. Box 764 Bronx N.Y. 10469

SECTION 1

AFFIRMATION

STATE OF NEW YORK, COUNTY OF Bronx ss: I, the undersigned, am an attorney duly admitted to the practice of law in the courts of the state of New York. I hereby certify that I have complied with the filing and service requirements for this Application for Full Board Review in the manner described in Section 2 below.

I affirm that the foregoing statements are true under penalties of perjury.

Dated _____ Signature Benjamin Holmes

Signer's Name (Print) Benjamin Holmes

AFFIDAVIT

STATE OF NEW YORK, COUNTY OF Bronx ss: I, Benjamin Holmes, being duly sworn, say: I am over 18 years of age. I hereby certify that I have complied with the filing and service requirements for this Application for Full Board Review in the manner described in Section 2 below.

Sworn to before me on _____ Signature _____

_____ Notary Public Signer's Name (Print) _____

SECTION 2

A. Method by which Application was Filed with the Board (Check One):

☐ Fax (1-877-533-0337) ☐ E-Mail (wcbclaimsfiling@wcb.state.ny.us) ☐ Mail (specify date below) ☐ Personal Delivery (specify date below)

Date of Mailing: _____ Date of Personal Delivery: _____

B. Method of Service on the Parties (Check One): ☐ Mail ☐ Personal Delivery

Specify Date of Mailing or Personal Delivery _____

C. Names and addresses of all Parties Served: (Attach additional sheets if necessary.)

Montefiore

01287053 HOLMES, Benjamin

Report Details:
Data assembled: 20Jun2012 13:08
Requested by: SMITH-JOHNSON RN , LORA J

Aggregate: DISCHARGE INSTRUCTIONS **Instructions for the patient**

**** Discharge Instruction FLOW**

Result DT:
Ent/Transc by: SMITH-JOHNSON RN , LORA J RN

Status: Final

Entered DT: 20Jun12 12:34

CLAIMANT'S REQUEST FOR REVIEW

MAIL TO:

⇊

WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
100 BROADWAY – MENANDS, ALBANY, NY 12241-0005

I acknowledge receipt of Notice of Rejection of my claim for Disability Benefits. I hereby request a review of the rejection of such claim for the following reasons: (Give complete details)

Acuso recibo del Aviso de Rechazo de mi reclamación de Beneficios por Incapacidad. Por la presente solicito una revision del rechazo de dicha reclamación, por las siguientes razones: (Dar detalles completos).

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date _____. Claimant's Signature _____

	INSTRUCTIONS TO CLAIMANT		INSTRUCCIONES AL(A LA) RECLAMANTE
1.	Give SPECIFIC reasons for requesting a review. You should file your Request for Review within 26 weeks.	1.	De usted las razones ESPECIFICAS que le hacen solicitar una revision. Usted debe mandar su Aviso de Rechazo antes de 26 semanas.
2.	Complete both copies of this form.	2.	Complete dos copies de esta forma.
3.	Mail one copy PROMPTLY to: Workers' Compensation Board Disability Benefits Bureau 100 Broadway – Menands Albany, New York 12241-0005	3.	Envie por correo, PRONTAMENTE, una copia a: Workers' Compensation Board Disability Benefits Bureau 100 Broadway – Menands Albany, New York 12241-0005
4.	Retain one copy for your own record.	4.	Quedese con una copia, para constancia.

Copies To:
Claimant: Benjamin Holmes
Carrier: *** Carrier Undetermined ***
Employer: Louis Leon
Other: Joseph A. Romano Law Offices

Benjamin Holmes
PO Box 964
Bronx, NY 10469-0705

NOTICE TO INJURED WORKER

1. Any compensation due will be sent to you by check by the employer or insurance carrier.

2. Keep a careful record of the payments received in order that you may have evidence of payment or nonpayment in case of dispute.

3. Do not pay anything to anyone representing you. If you hire a lawyer or licensed representative, the fee will be set by a W.C.Law Judge. The fee will be deducted from your award and paid by separate check directly to the lawyer or licensed representative by the employer or the insurance carrier.

4. Except for Volunteer Firefighters' and Volunteer Ambulance Workers' claims, no lost wage benefits are paid for the first seven days of disability unless the disability extends beyond 14 days.

5. If your case was continued and the Judge directed that your benefits are to continue, the insurance company or self-insured employer must keep paying you until :

   (a) you have another hearing and the Judge stops or changes your benefits

   or

   (b) your employer or insurance company has evidence that you have returned to work at regular pay or a report from your doctor stating you have no disability and submits this evidence to the Workers' Compensation Board.

6. If you wish to apply for administrative review of any part or all of the Judge's decision, your application must be in writing and received by the Board within 30 days of the filing date of this decision. The filing date is on the other side of this form in the lower right-hand corner. You may deliver your application in person to the District office or send it by mail.

7. If you have any further questions, you may contact your district office by mail or by telephone. The address of your district office is:

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205

Phone Number: (866) 746-0552

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.state.ny.us

(866) 746-0552

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #0792 5837

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 02/10/2010 involving the claim of Benjamin Holmes at the Yonkers hearing location, Judge Mark Oberman made the following decision, findings and directions:

DECISION: Prima facie medical evidence exist for the back per Dr. Katzman 10/20/09.

Discharge and remove Joseph A. Romano, Es.

C-7s raised including Section 28.

Claimant to produce prima facie medical evidence re: causally related heart/stroke.

Claimant advised to retain counsel, but may proceed without. The case is continued to address the following issue(s): Prima Facie Medical Evidence, Accident Within Meaning Of Workers' Compensation Law, Accident Arising Out Of And In The Course Of Employment, Occupational Disease Within Meaning Of Workers' Compensation Law, Occupational Disease Arising Out Of And In The Course Of Employment, Notice (Section 18), Notice (Section 45), Employer-Employee Relationship, Causally Related Accident Or Occupational Disease, Cancellation Of Coverage, Proper Carrier, Timely Filing (Section 28). This case is not subject to the expedited hearing process and penalties.

Information about Next Hearing / Meeting
3/22/10 at 3:00 p.m. Testimony of claimant, 2 employer witnesses, and summations.

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision -	02/18/2010

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205
www.wcb.state.ny.us

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

ROBERT E. BELOTEN
CHAIR

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

June 17, 2010

In response to the claimant:
In the Request for Further Action form of 05/31/2010 you indicated that you have requested a hearing.

Based upon your request the Board is scheduling the case for a hearing; you will receive a notice of hearing giving a date, time, and location in the near future.

Workers' Compensation Board

Ms. Smalls
(866)746-0552

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	07925837	Carrier ID No.:	W204002
Date of Accident:	07/30/1979	Carrier Case No.:	050494331
Employer:	Louis Leon D/B/A L. L. Gulf Gas Station	Insurance Carrier:	State Insurance Fund

ROBERT E. BELOTEN
CHAIR

STATE OF NEW YORK
WORKERS'COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
100 BROADWAY – MENANDS
ALBANY, NY 12241-0005
1-800-353-3092

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Date: December 31, 2009

OFFICE AT: ALBANY

BENJAMIN HOLMES
PO BOX 764
BRONX NY 10469

CLAIMANT: RETURN BOTH COPIES OF THIS FORM

DATE OF THIS NOTICE	CARRIER FILE NUMBER	SOCIAL SECURITY NUMBER
December 31, 2009		XXX-XX-3996

☒ 1. You have not furnished adequate proof of disability and medical care for the period from 7/30/09. Disability benefits may not be paid for any period for which such proof has not been submitted. Please give this letter and the enclosed envelope to the doctor or nurse-midwife who attended you on or about the date shown above so that the required proof may be promptly submitted.

☐ 2. Your claim must be supported by medical evidence for the period for which the insurance carrier denied payment. Have your doctor or nurse-midwife complete the items on the reverse and:

☐ Mail both copies of this form to the Disability Benefits Bureau, 100 Broadway-Menands, Albany, New York 12241-0005. If we do not hear from you within ten days, we shall refer this case to our closed files.

☐ Bring both copies of this form to the hearing which will be scheduled on your claim. You will be notified of the place, date and time of this hearing. If you are still disabled, it is suggested that you wait until shortly before the hearing date to have this form completed. **You are urged to attend the hearing which will be scheduled.** However, if you are unable to attend, please mail this form, completed by your doctor or nurse-midwife, to the Workers' Compensation Board at the office indicated above and advise them of the reason that you will not be able to attend the hearing.

DISABILITY BENEFITS BUREAU

IF YOU HAVE ANY QUESTIONS OR NEED ADVICE ABOUT YOUR CLAIM, YOU MAY CALL OR VISIT THE NEAREST OFFICE OF THE WORKERS' COMPENSATION BOARD.

SI USTED TIENE ALGUNAS PREGUNTAS O NECESITA CONSEJO SOBRE SU RECLAMACION, USTED PUEDE LLAMAR O VISITAR LA OFICINA DE LA JUNTA DE COMPENSACION MAS CERCANA A USTED.

HEALTH PROVIDER: PLEASE COMPLETE REVERSE OF THIS FORM

CP:ML 300

STATE OF NEW YORK
WORKERS'COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
100 BROADWAY – MENANDS
ALBANY, NY 12241-0005
1-800-353-3092

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

NOTICE OF REJECTION OF CLAIM FOR DISABILITY BENEFITS
AVISO DE RECHAZO DE RECLAMACION DE BENEFICIOS POR INCAPACIDAD
(Special Fund for Disability Benefits)

BENJAMIN HOLMES PO BOX 764 BRONX, NY 10469	Date: Claimant's SS No.:	January 8, 2010 XXX-XX-3996

You are hereby notified that your claim for Disability Benefits is rejected under the Disability Benefits Law for the reason(s) checked below:

First day of disability
Date claim filed

☐ 1. Your claim was not filed within 26 weeks after the date your disability commenced

☐ 2. Your claim was not filed within 30 days after the date your disability commenced. (See item 4 on reverse.)

- ☐ A. No benefits payable
- ☐ B. Payments are being made beginning two weeks prior to the date your claim was filed.

☐ 3. Benefits from the Special Fund are provided for the unemployed who become disabled while claiming Unemployment Insurance. Since you were not claiming and/or receiving Unemployment Insurance immediately prior to your disability, as required by law, you are not entitled to benefits from the Special Fund.
IF YOU CONTEST THE REJECTION OF YOUR CLAIM FOR THIS REASON, FORWARD TO US EVIDENCE THAT YOU WERE CLAIMING OR RECEIVING UNEMPLOYMENT INSURANCE BENEFITS. THIS EVIDENCE MAY BE OBTAINED FROM YOUR LOCAL UNEMPLOYMENT INSURANCE OFFICE.

☐ 4. Disability Benefits are payable only for disabilities which commence within the first twenty-six weeks following termination of employment. The information in your claim indicates that your disability commenced more than twenty-six weeks after the termination of your last employment.

Last Day Worked ___ 26 Weeks Ended ___ Disability Began

☐ 5. You have not complied with our requests for information necessary to process your claim. (See Item 7, below.)

☐ 6. The medical reports on file do not indicate you were totally disabled beyond the date you have already been paid Disability Benefits. Your claim is, therefore, rejected for the period beyond ___ . If you were still disabled after that date, submit additional medical evidence immediately.

X 7. Other: 1) INFORMATION CONTAINED IN YOUR CLAIM INDICATES THAT YOUR DISABILITY MAY HAVE RESULTED FROM AN ACCIDENTAL INJURY ARISING IN AND OUT OF THE COURSE OF EMPLOYMENT, OR FROM AN OCCUPATIONAL DISEASE. THE DISABILITY BENEFITS LAW PROVIDES THAT NO DISABILITY BENEFITS ARE PAYABLE FOR ANY PERIOD FOR WHICH WORKERS' COMPENSATION BENEFITS ARE PAID OR PAYABLE.
2) UNDER SECTION 206.1A ANY PERIOD FOR WHICH YOU ARE COLLECTING SOCIAL SECURITY DISABILITY BENEIFTS IS NOT PAYABLE. DUPLICATION OF BENEFITS IS PROHIBITED.
3) BE ADVISED TO REOPEN YOUR COMPENSATION CASE # G0123585 AND PURSUE.

TO CLAIMANT: READ IMPORTANT INSTRUCTIONS FOR REQUESTING REVIEW ON REVERSE OF THIS FORM.
AL (A LA) RECLAMANTE: LEA, EN EL REVERSO DE ESTA FORMA, INSTRUCCIONES IMPORTANTES PARA SOLICITAR REVISION.

STATE OF NEW YORK
WORKERS'COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
100 BROADWAY – MENANDS
ALBANY, NY 12241-0005
1-800-353-3092

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

DATE: January 8, 2010

BENJAMIN HOLMES
PO BOX 764
BRONX, NY 10469

LAST EMPLOYER	SOCIAL SECURITY NUMBER
NEW YORK DEPARTMENT OF PARKS	XXX-XX-3996

We have your claim for Disability Benefits. We regret that it appears, from your claim and other information we have received, that you are not eligible under the Disability Benefits Law because:

x You did not work for a "covered" employer within the meaning of the Disability Benefits Law for at least four consecutive weeks immediately prior to the commencement of your disability.

☐ You previously established eligibility by working four consecutive weeks or more for a "covered" employer and have since worked in excess of four weeks for an employer who is not "covered" under the provisions of the Disability Benefits Law.

The above is based on the following:

MUNICIPAL (CITY OF NEW YORK) EMPLOYMENT IS EXCLUDED FROM NEW YORK STATE DISABILITY BENEFITS LAW.

TO CLAIMANT: READ IMPORTANT INSTRUCTIONS FOR REQUESTING REVIEW ON REVERSE SIDE.

AL (A LA) RECLAMANTE: LEA, EN DE ESTA FORMA, INSTRUCCIONES IMPORTANTES PARA SOLICITAR REVISION.

Copies To:
Claimant: Benjamin Holmes
Carrier: State Insurance Fund
Employer: Louis Leon
Other: Joseph A. Romano Law Offices

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

NOTICE TO INJURED WORKER

1. Any compensation due will be sent to you by check by the employer or insurance carrier.

2. Keep a careful record of the payments received in order that you may have evidence of payment or nonpayment in case of dispute.

3. Do not pay anything to anyone representing you. If you hire a lawyer or licensed representative, the fee will be set by a W.C.Law Judge. The fee will be deducted from your award and paid by separate check directly to the lawyer or licensed representative by the employer or the insurance carrier.

4. Except for Volunteer Firefighters' and Volunteer Ambulance Workers' claims, no lost wage benefits are paid for the first seven days of disability unless the disability extends beyond 14 days.

5. If your case was continued and the Judge directed that your benefits are to continue, the insurance company or self-insured employer must keep paying you until :

   (a) you have another hearing and the Judge stops or changes your benefits

   or

   (b) your employer or insurance company has evidence that you have returned to work at regular pay or a report from your doctor stating you have no disability and submits this evidence to the Workers' Compensation Board.

6. If you wish to apply for administrative review of any part or all of the Judge's decision, your application must be in writing and received by the Board within 30 days of the filing date of this decision. The filing date is on the other side of this form in the lower right-hand corner. You may deliver your application in person to the District office or send it by mail.

7. If you have any further questions, you may contact your district office by mail or by telephone. The address of your district office is:

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205

Phone Number: (866) 746-0552

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205
www.wcb.state.ny.us

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

ROBERT E. BELOTEN
CHAIR

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

April 22, 2010

In response to the claimant:
In the Request for Further Action form of 04/13/2010 you indicated that you have requested a hearing.

Based upon your request:

No action will be taken on your case until you submit all documents requested by the Law Judge per decision filed 4/19/10.

Workers' Compensation Board

Ms. Smalls
(866)746-0552

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	07925837	Carrier ID No.:	W204002
Date of Accident:	07/30/1979	Carrier Case No.:	050494331
Employer:	Louis Leon D/B/A L. L. Gulf Gas Station	Insurance Carrier:	State Insurance Fund

NOTICE OF WORKERS COMPENSATION HEARING

State of New York
WORKERS' COMPENSATION BOARD

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board 215 W. 125th Street, 4th Floor New York, NY 10027	21	10/10/2012	9:00 AM 15 Min	NYC (800) 877-1373
	WCB Case No.		Date of Accident	WCB Home Page
	G0477983		11/01/2006	www.wcb.ny.gov
			Carrier ID No.	Carrier Case No.
			W847008	0846-12-02699
			CLAIMANT	
			Benjamin Holmes	

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

CLAIMANT: Bring this notice with you. Read important information on reverse side.

EMPLOYER NYC Parks & Recreation

CARRIER City of New York
c/o NYC Law Dept

COPIES TO Benjamin Holmes
Joseph A. Romano Law Offices

NOTICE OF PRELIMINARY HEARING:

See reverse side for important information about this preliminary hearing. Both Claimant and carrier are to be present prepared to furnish the information described on reverse side in order to fix a date for trial hearing. On the date set for trial hearing, the case will be decided on the evidence presented. There will be no further adjournment at that time except for good and sufficient cause.

PURPOSE OF HEARING:

Production of medical evidence.

EVIDENCE TO BE PRODUCED:

By Claimant: Claimant to produce medical.

IMPORTANT INFORMATION FOR THE CLAIMANT:

In a compensable workers' compensation case, bills for related medical treatment are the responsibility of your own employer or its workers' compensation insurance carrier. If you have used a private health insurance policy (Blue Cross, Blue Shield, G.H.I., H.I.P., or other) for payment of any bills in your workers' compensation case, please advise the private health insurer immediately.

In order to be reimbursed for any payments or co-payments you may have made for treatment or services which are the responsibility of the workers' compensation insurance carrier, you must tell the judge at this hearing about this payment.

THE NEW YORK STATE WORKERS' COMPENSATION BOARD PROHIBITS VISITORS, EMPLOYEES, CLIENTS OR WITNESSES FROM CARRYING OR BEARING FIREARMS OR ANY OTHER WEAPON ON BOARD PREMISES.

Dated: 09/24/2012

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

Robert E. Beloten
Chair

ADMINISTRATIVE REVIEW DIVISION
WORKERS' COMPENSATION BOARD
20 PARK ST
ALBANY, NY 12207
www.wcb.state.ny.us

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #0792 5837

MEMORANDUM OF BOARD PANEL DECISION

keep for your records

Opinion By: Donna Ferrara
Frances Libous
Samuel G. Williams

The claimant, appearing without the aid of counsel, is requesting review of the Workers' Compensation Law Judge's decision filed on July 12, 2010. A timely served rebuttal has been received.

ISSUE

The issue presented for administrative review is whether the case should be reopened.

FACTS

In December 2008, the claimant requested a reopening of his claim. The Board has no record of this claim and the claimant filed a C-3.0 form. From a review of the information provided by the parties, the following facts can be gleaned.

The claimant worked for Louis Leno d/b/a L & L Gulf Gas Station in 1979. A claim for workers' compensation benefits was filed against the employer. The Workers' Compensation Board indexed the claim in 1979 as Case No. 07925837. Encompassins, which took over claims for CNA Insurance, which had taken over claims for Fireman's Fund Insurance Co. has a record of a claim for the claimant from an accident that occurred on August 1, 1979, but they have no

*** *Continued on next page* ***

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision -	01/26/2011

ATENCION:
Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

further information.

In 1999, the claimant sought a reopening of the claim and was advised by the Workers' Compensation Board that the file was destroyed because it was inactive and more than eighteen years old.

The claimant contends that his claim was established for several injuries and he was awarded compensation benefits. He further contends that the accident gave rise to a third-party action, which settled with the carrier's consent and that the carrier took a credit for the third-party recovery.

In a Notice of Decision filed on July 12, 2010, the Workers' Compensation Law Judge disallowed the claim because there was no evidence of a claim. The claimant was permitted to reopen the claim if further evidence is produced. The claimant now seeks administrative review of the decision, asserting that the Workers' Compensation Law Judge ignored the fact that he has a claim number from 1979.

LEGAL ANALYSIS

The claim for compensation benefits is denied pursuant to Workers' Compensation Law § 123.

The existence of a claim number is evidence that a claim for workers' compensation benefits was filed in 1979. There is insufficient evidence as to whether the claim was established, denied, or closed pursuant to Workers' Compensation Law § 15(5-b). Based upon the passage of time before the 1999 reopening and the 2008 reopening, it is clear that outstanding issues were resolved and the case was marked for no further action.

Regardless of whether the claim was established or disallowed, the claim for compensation benefits is barred by the provisions of Workers' Compensation Law § 123.

If the claim was disallowed or otherwise disposed of without a finding on the merits, then the claim cannot be reopened more than seven years after the date of accident. If the claim was established, then a payment of compensation benefits cannot be made more than eighteen years after the date of accident.

Therefore, the Board Panel finds, upon review of the record and based upon a preponderance of the evidence, that the claim for compensation benefits is denied.

*** *Continued on next page* ***

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision -	01/26/2011

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

CONCLUSION

ACCORDINGLY, the Workers' Compensation Law Judge's decision filed on July 12, 2010 is MODIFIED to find the claim for compensation benefits is barred by Workers' Compensation Law § 123. No further action is planned at this time.

All concur.

Donna Ferrara

Frances Libous

Samuel G. Williams

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision -	01/26/2011

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

FILE COPY

Please see reverse for Recipients.

DATE OF MAILING	CLAIMANT'S S.S. NO.
11/7/2011	
WCB CASE NO.	DATE OF ACCIDENT
G0477983	11/01/2006
CARRIER CASE NO.	CARRIER I.D. NO.
	W847008

CLAIMANT'S NAME	EMPLOYER'S NAME	CARRIER'S NAME
Benjamin Holmes	NYC Parks & Recreation	City of New York

NOTICE OF CANCELLATION OF CASE NUMBER

The case identified above was a **duplicate file** and has been cancelled. All records pertaining to this case have been combined with WCB case number G0123585 Use only this number in all future communications regarding this case.

Please note your records accordingly.

By Ms.L.Sanchez Unit 10

Telephone No. (800)877-1373

EC-84.2 (6/21/95)

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

FILE COPY

Please see reverse for Recipients.

DATE OF MAILING	CLAIMANT'S S.S. NO.
4/19/2012	
WCB CASE NO.	DATE OF ACCIDENT
G0477983	11/01/2006
CARRIER CASE NO.	CARRIER I.D. NO.
	W847008

CLAIMANT'S NAME	EMPLOYER'S NAME	CARRIER'S NAME
Benjamin Holmes	NYC Parks & Recreation	City of New York

Mail addressed **to the claimant** at the following address has been returned by postal authorities:

Benjamin Holmes
PO Box 764
Bronx, NY 10469

Failure to locate the claimant will result in non-payment of an award to which he or she may be entitled under the law. We therefore request that you complete the lower portion of this form and return this letter to the Board office indicated at the top of this form.

By Sandra Burke-Arrington Unit C-7

Telephone No. (800)877-1373

1. [X] Check here if your records indicate same address as shown above.

2. [ ] Claimant's present address is: **(Please type or print clearly)**

Name Benjamin Holmes

Street P. O. Box 764

City Bronx

State New York Zip Code 10469

Telephone Number 347-313-6258

EC-341 (6/21/95)

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205

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FILE COPY

ROBERT E. BELOTEN
CHAIR

Please see reverse for Recipients.

February 28, 2012

In order to evaluate and resolve a claim for workers' compensation benefits, the Board requires medical reports concerning the injury, trauma or illness and degree of impairment.

The employer or insurance carrier has objected to this claim by filing Form C-7, Notice of Controversy. To resolve this issue as quickly as possible, the Workers' Compensation Board needs a properly completed medical report. The Law requires that a pre-hearing conference be held within 30 days of receipt of Form C-7 and a medical report referencing the claimant's injury. Without a properly completed medical report, the Board is unable to schedule this conference.

Examiner: Sandra Burke-Arrington
Telephone No.(800)877-1373

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	G0477983	Carrier ID No.:	W847008
Date of Accident:	11/01/2006	Carrier Case No.:	
Employer:	NYC Parks & Recreation	Insurance Carrier:	City of New York c/o NYC Law Dept

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

FILE COPY

ROBERT E. BELOTEN
CHAIR

Please see reverse for Recipients.

December 29, 2011

Under the Workers' Compensation Law, the insurance carrier or employer is required to complete and file without delay the following forms which are needed to complete the Board's file. The injured worker does not need to take any action based on this notice.

C-2, C-4, C-11, C-8/8.6, C-240, Employer's Statement of Wage Earnings (If claimant did not work a full year preceding the date of accident, submit payroll of similar worker.), Reimbursement Request

Section 25-3(e) of the Workers' Compensation Law provides that a penalty of $50 may be imposed for failure to file a notice or report requested or required by the Chair or Board within 10 days.

By: Emmett O'Donnell
Telephone No.(800)877-1373

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	G0477983	Carrier ID No.:	W847008
Date of Accident:	11/01/2006	Carrier Case No.:	
Employer:	NYC Parks & Recreation	Insurance Carrier:	City of New York c/o NYC Law Dept

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov

(800) 877-1373

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 11/28/2012 involving the claim of Benjamin Holmes at the Manhattan hearing location, Judge William Dugan made the following decision, findings and directions:

DECISION: Claim is disallowed.
Claim is barred by Sections 18 and 28.

Claimant's counsel notes exceptions.
No further action is planned by the Board at this time.

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of New York
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	12/03/2012

ATENCION:
Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

EC-23 (4/98)

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov
(877) 632-4996

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF PROPOSED DECISION

keep for your records

This decision makes legal findings about your on-the-job injury. It was made based on information in the Board's file as of this date.

The Findings section of this decision may state information such as what part of your body was injured; how much you were earning before you got hurt; how long you were out of work; whether you were entitled to be paid compensation benefits while you were out of work; the amount of weekly workers' compensation benefits; and if you have approval for medical treatment.

These legal findings are important and may limit your claim for workers' compensation benefits. If you DISAGREE with any part of this decision you must OBJECT. Write your objection on the back of this form and return it to the address listed above. The proposed decision will become FINAL on 8th day of July, 2014 so ANY OBJECTION to it must be RECEIVED by the Board BEFORE that date to be considered timely. Objections received on or after that date, will not be considered.

If you DO NOT UNDERSTAND this decision, you may contact the Board at 1-877-632-4996 for further information.

If you are not represented by legal counsel, you may want to consult an attorney or a licensed representative to assist you with your claim. An attorney or a licensed representative cannot charge you directly for representation in a workers' compensation case. If there is an award in your case, any legal fee request must be approved by the Board and will be deducted from the award to you by the insurance carrier and paid directly to the attorney or the licensed representative.

PROPOSED DECISION

FINDINGS: Form(s) C-8.1 which raised issues relating to treatment and/or disputed medical bills are resolved in favor of the carrier C-8.1B dated 3/21/14. Claim disallowed.

No further action is planned by the Board at this time.

*** *Continued on next page* ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	06/03/2014

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205
www.wcb.state.ny.us

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

ROBERT E. BELOTEN
CHAIR

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

March 21, 2011

In response to the claimant:
In the phone call of 03/17/2011 you indicated that you need another RB-89.2.

Based upon your request:

Enclosed. Please send a copy of the completed paperwork to the carrier as well as the Board. Thank you.

Workers' Compensation Board

Margaret Morrissey
(866)746-0552

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	07925837	Carrier ID No.:	W204002
Date of Accident:	07/30/1979	Carrier Case No.:	050494331
Employer:	Louis Leon D/B/A L. L. Gulf Gas Station	Insurance Carrier:	State Insurance Fund

Copies To:
Claimant:
Carrier:
Employer:
Other:

Case #G047 7983
Benjamin Holmes
City of NY Other Than Ed, High
NYC Parks & Recreation
Joseph A. Romano Law Offices
Avraham Henoch

Benjamin Holmes
PO Box 764
Bronx, NY 10469

Claimant's Address
Benjamin Holmes
PO Box 764
Bronx, NY 10469

NOTICE TO THE INJURED WORKER

1. AVERAGE WEEKLY WAGE--The average weekly wage established is based on an average of your earnings for an entire year prior to your injury and so may differ from your weekly salary on the date of your accident.

2. AWARD--Your rate per week for 100% disability is calculated at two-thirds of your average weekly wage up to a maximum established by law at the time of your accident. If your doctor indicates a partial disability, your rate may be lower. If your employer paid your wages while you were out of work and requests reimbursement, you are not entitled to any cash benefits for that period. Any compensation due will be mailed to you by check from the employer or insurance carrier no later than 10 days following the FINAL date listed on the first page of the Proposed Decision. No awards are payable for the first 7 days of lost time unless lost time exceeds 14 total days. This 7-day waiting period does not apply to volunteer firefighters and volunteer ambulance workers.

3. PERMANENT INJURY--If your injury has resulted in a permanent loss of eyesight, hearing, or serious facial scar, or any permanent defect in a finger, hand, toe, foot, leg, or arm, a medical report indicating permanency should be forwarded to the Board. (Form C-4.3, Doctor's Report of MMI/Permanent Impairment) The Board will then process your request for a finding regarding permanency. A finding of permanency may result in additional compensation.

4. NO FURTHER ACTION IS PLANNED--This means that all current legal issues in your claim have been resolved and that there are no issues in dispute at this time that require Board resolution. Unless otherwise stated in the Proposed Decision, you are entitled to continued related necessary medical treatment as the course of recovery requires. If the carrier or self-insured employer disputes or declines to cover any future medical treatment, you may request further Board action. If you require further action by the Board, please use Form RFA-1W, Request for Assistance by Injured Worker which is available on the Board's website or which can be mailed to you upon request.

5. ATTORNEY/REPRESENTATIVE--You have the right to be represented by an attorney or licensed representative at any time during the processing of your claim. If you choose to be represented, you should not pay your representative directly. His or her fee will be set by the Workers' Compensation Board and will be deducted from any money awarded to you.

OBJECTION TO THE DECISION

STATE THE REASON(S) FOR YOUR OBJECTION: _____

_____

_____

_____

Signature Date Telephone Number

Carriers and Self Insured Employers must send a copy of the Objection to the Claimant and Claimant's Representative, if any.

PD-NSL (12/10)

OVER

Robert E. Beloten
Chair

ADMINISTRATIVE REVIEW DIVISION
WORKERS' COMPENSATION BOARD
20 PARK ST
ALBANY, NY 12207
www.wcb.ny.gov

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #0792 5837

AMENDED MEMORANDUM OF BOARD PANEL DECISION

keep for your records

Opinion By: Donna Ferrara
Frances Libous
Samuel G. Williams

This Board Panel, upon the direction of the Chair of the Workers' Compensation Board and pursuant to Workers' Compensation Law (WCL) § 142 and 12 NYCRR 300.16, has reviewed and considered the claimant's application for discretionary Full Board Review, received on April 8, 2011, of the Board Panel Memorandum of Decision (MOD) filed on January 26, 2011, in the above cited case. Based on that review, the Board Panel has determined that Full Board Review is not warranted. The Board Panel, however, has determined that the MOD should be amended as indicated below.

This decision amends and supersedes the Board Panel MOD filed on January 26, 2011, to rescind, without prejudice, the finding that the claim for compensation benefits is denied as barred by WCL § 123,, to direct that Encompass Insurance Company be placed on notice as the potential carrier in this case, and to direct that the case be continued for further development of the record on the issue of proper carrier and existence of an accepted or established workers' compensation claim.

The claimant requests review of the Workers' Compensation Law Judge (WCLJ) decision filed on July 12, 2010. The insurance carrier filed a rebuttal.

ISSUE

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision– 02/17/2012	

ATENCION:
Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

The issue presented for administrative review is whether the claimant's claim for compensation benefits was properly found to be barred pursuant to WCL § 123.

FACTS

By claim form C -3.0 filed December 19, 2008, the claimant contends he was involved in an on-the-job accident while working as a car mechanic on July 30, 1979, resulting in multiple injuries. The claimant also contends he filed a workers' compensation claim, that the claim was established, that he received benefits, and that a third party action was undertaken and settled with the carrier's consent.

The claimant worked as a car mechanic for Louis Leon d/b/a L & L Gulf Gas at the time of injury. There was a record for a claim of this date and the case was assigned the WCB case number of 0792 5837. In 1999, the claimant sought a reopening of the claim and was advised by the Board that the file was destroyed because it was inactive and was more than eighteen years old (*see* CIS doc. # 179303860, filed April 8, 2011).

To date, the claimant has been unable to present any other documentary evidence showing his claim was actually established by the Board, the body sites or injuries for which it was established, that the carrier paid for any treatment, or that a third party settlement was undertaken or settled.

At a hearing held on July 12, 2010, the WCLJ explained to the claimant the documentation that would have to be produced if the claimant sought lost time awards in relation to the claim. The claimant presented a 1985 medical script and a recent statement from his doctor. The WCLJ found these to be insufficient evidence that the claim had been previously established and disallowed the claim without prejudice to the claimant's production of additional documentation in support of his claim.

The Board Panel, in a decision filed January 26, 2011, modified the WCLJ's decision and found that even if the claim had been established, any claim now set forth would be time barred pursuant to WCL§ 123. The Board found that if the claim was disallowed or otherwise disposed of without a finding on the merits, the claim could not be reopened more than seven years after the date of accident (July 30, 1986) and that if the claim had been established, that a payment of compensation could not now be directed more than eighteen years (July 30, 1997) after the accident date.

*** *Continued on next page* ***

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision–	02/17/2012

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

LEGAL ANALYSIS

The claimant contends that the MOD should be rescinded because he believes the starting point for the claim should be 1985 and not 1979 because that is the date he received his last payment, that he has a learning disability, and the MOD is unfair.
The carrier argues that the MOD is correct and should be affirmed.

"As an exception to the Board's continuing jurisdiction over workers' compensation claims, Workers' Compensation Law § 123 provides, in relevant part, that 'no claim for compensation . . . that has been . . . disposed of without an award after the parties in interest have been given due notice of hearing or hearings and opportunity to be heard and for which no determination was made on the merits, shall be reopened after a lapse of seven years from the date of the accident.' As a factual determination for the Board to make, whether such cases fall within the ambit of this statute depends on whether they were truly closed, that is, if further proceedings, such as the submission of additional medical evidence, were contemplated by the Board" *Matter of Ford v New York City Tr. Auth.*, 27 AD3d 792 [2006], *appeal dismissed* 7 NY3d 741 [2006] [citations omitted]).

"Section 123 provides the Workers' Compensation Board with authority to reopen closed cases, subject to the time limitation that no awards shall be made against the Special Fund or against an employer where the application is made 'after a lapse of eighteen years from the date of the injury or death and also a lapse of eight years from the date of the last payment of compensation'. This 'eighteen-and eight'-year time limitation applies only to cases which have been closed and are being reopened, but would not bar a new claim or continuing consideration of an open case" (*Matter of Zechmann v Canisteo Volunteer Fire Dept.*, 85 NY2d 747 [1995] [citations omitted]).

The electronic case folder contains documentation that an entity not previously placed on notice, or present for hearings in this matter, Encompass Insurance Company, may in fact be the proper carrier in this claim, and may have documentation which could be utilized to determine whether the claimant has an accepted or established 1979 back injury claim. This documentation is a memo dated May 24, 2010, addressed to the claimant from Herbert Berman with an attached email from Gail Rock of Encompass Insurance Company (see the claimant's May 31, 2010 RFA-1, CIS doc. # 166911580, filed June 3, 2010, pp. 10-11) and indicates administration of the claimant's 1979 claim was taken over by CNA Insurance from Fireman's Fund Insurance, and thereafter, by Encompass Insurance Company. This documentation further indicates *that a claim was filed on August 1, 1979*, the insured was Louis Leon d/b/a L & L Gulf Gas Station, and the (carrier) case number was 33786765. There is no indication this important documentary

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision--	02/17/2012

ATENCION:
Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

evidence was considered by the WCLJ. Encompass has not been placed on notice for any hearing and thus has not been asked to produce its file. Even if it is determined the claimant's claim was never formally established by the Board, it may still be compensable if the carrier accepted liability for the claim. Encompass Insurance Company should therefore be placed on notice to be present at future hearings, and should be directed to produce any and all documentary or other evidence it has relating to this claim, in order to determine whether there is any additional information regarding the acceptance and/or establishment of the claimant's 1979 back injury claim.

Further, as a WCL§ 123 finding depends on a finding of true closure, and information from Encompass Insurance Company may demonstrate there was no true closure, it was premature to find WCL§ 123 applies in this case pending Encompass being placed on notice and being directed to be present at hearings with its file documents and other evidence it may have that relates to this claim. Thus, Encompass Insurance Company is to be placed on notice as the potential carrier in this case, and the case is continued for further development of the record on the issue of proper carrier and existence of an accepted or established workers' compensation claim.

Finally, it should be noted that even if WCL§ 123 applies to bar the claimant from receiving any further lost wage benefits in an accepted/established case, it does not bar the claimant from receiving medical benefits for causally related injuries or conditions. (*see Matter of Youngelman v NYC Dept. of Sanitation*, 10 AD2d 173 [1960], *appeal dismissed*, 9 NY2d 905 [1961]; *see also Matter of Daum v Rochester State Hospital*, 21 AD2d 953 [1964]; *Matter of Pixley v University of Rochester*, 22 AD2d 743 [1964], *appeal denied*, 15 NY2d 483 [1965]).

CONCLUSION

ACCORDINGLY, the WCLJ decision filed on July 12, 2010 is MODIFIED to rescind, without prejudice, the finding that the claim is disallowed. Further, Encompass Insurance Company is to be placed on notice as the potential carrier in this case and is to be present at future hearings with its file documents and any other evidence it may have that relates to this claim. This case is continued for further development of the record on the issue of proper carrier and the existence

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision–	02/17/2012

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

of an accepted or established workers' compensation claim, as indicated above, and whether WCL § 123 applies in this case.

All concur.

Donna Ferrara | Frances Libous | Samuel G. Williams

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision–	02/17/2012

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

Copies To:
Claimant:
Carrier:
Employer:
Other:

Benjamin Holmes
State Insurance Fund
Louis Leon D/B/A

Please see below for Recipients.

Benjamin Holmes
P.O. Box 764
Bronx, NY 10469

Louis Leon D/B/A
L. L. Gulf Gas Station
1101 Grenada Place
Bronx, NY 10466

State Insurance Fund
105 Corporate Park Dr, Ste 200
White Plains, NY 10604-3814

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov
(877) 632-4996

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF PROPOSED DECISION

keep for your records

This decision makes legal findings about your on-the-job injury. It was made based on information in the Board's file as of this date.

The Findings section of this decision may state information such as what part of your body was injured; how much you were earning before you got hurt; how long you were out of work; whether you were entitled to be paid compensation benefits while you were out of work; the amount of weekly workers' compensation benefits; and if you have approval for medical treatment.

These legal findings are important and may limit your claim for workers' compensation benefits. If you DISAGREE with any part of this decision you must OBJECT. Write your objection on the back of this form and return it to the address listed above. The proposed decision will become FINAL on 8th day of July, 2014 so ANY OBJECTION to it must be RECEIVED by the Board BEFORE that date to be considered timely. Objections received on or after that date, will not be considered.

If you DO NOT UNDERSTAND this decision, you may contact the Board at 1-877-632-4996 for further information.

If you are not represented by legal counsel, you may want to consult an attorney or a licensed representative to assist you with your claim. An attorney or a licensed representative cannot charge you directly for representation in a workers' compensation case. If there is an award in your case, any legal fee request must be approved by the Board and will be deducted from the award to you by the insurance carrier and paid directly to the attorney or the licensed representative.

PROPOSED DECISION

FINDINGS: Form(s) C-8.1 which raised issues relating to treatment and/or disputed medical bills are resolved in favor of the carrier C-8.1B dated 3/21/14. Claim disallowed.

No further action is planned by the Board at this time.

*** *Continued on next page* ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	06/03/2014

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov
(800) 877-1373

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 09/19/2012 involving the claim of Benjamin Holmes at the Manhattan hearing location, Judge William Dugan made the following decision, findings and directions:

DECISION: Issues in controversy (C-7 issues) have been raised by the carrier/employer.

I was there 30 minutes late

Claimant did not appear at the hearing, or was otherwise not prepared to proceed - there is no medical in the file.

. The case is continued to address the following issue(s): Accident Within Meaning Of Workers' Compensation Law, Accident Arising Out Of And In The Course Of Employment, Occupational Disease Within Meaning Of Workers' Compensation Law, Occupational Disease Arising Out Of And In The Course Of Employment, Notice (Section 18), Timely Filing (Section 28). This case is not subject to the expedited hearing process and penalties.

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of New York
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	09/24/2012

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205
www.wcb.state.ny.us

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

ROBERT E. BELOTEN
CHAIR

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

July 14, 2010

Per your phone call on 7/12/09, Please contact the Advocate for Injured Workers' at 1-800-580-6665 for further assistance.

For further action by the board, please comply with decision filed 7/12/10.

By: Ms. Smalls
Telephone: (866)746-0552

Your "W.C.B. Case No." is important. In the future, please refer to the "W.C.B. Case No." below so that we could expedite the processing of the correspondence you send us.

Su numero de caso "W.C.B. Case No." es importante. En el futuro, indique el numero de su caso "W.C.B. Case No." que aparece de abajo para poder porcesar la correspondencia que usted nos mande mas rapidamente.

1800 877 1373

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	07925837	Carrier ID No.:	W204002
Date of Accident:	07/30/1979	Carrier Case No.:	050494331
Employer:	Louis Leon D/B/A L. L. Gulf Gas Station	Insurance Carrier:	State Insurance Fund

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov
(800) 877-1373

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 11/28/2012 involving the claim of Benjamin Holmes at the Manhattan hearing location, Judge William Dugan made the following decision, findings and directions:

DECISION: Claim is disallowed.
Claim is barred by Sections 18 and 28.

Claimant's counsel notes exceptions.
. No further action is planned by the Board at this time.

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of New York
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision–	12/03/2012

ATENCION:
Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

EC-23 (4/98)
FILE COPY

Copies To:
Claimant:
Carrier:
Employer:
Other:

Benjamin Holmes
City of New York
NYC Parks & Recreation
Joseph A. Romano Law Offices

Please see below for Recipients.

Benjamin Holmes
PO Box 764
Bronx, NY 10469

NYC Parks & Recreation
24 West 61st St
New York, NY 10023

City of New York
c/o NYC Law Dept
Workers' Compensation Division
350 Jay Street, 9th Floor
Brooklyn, NY 11201

Joseph A. Romano Law Offices
703 Yonkers Avenue
Yonkers, NY 10704

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DOWNSTATE CENTRALIZED MAILING (for New York City, Hempstead, Hauppauge & Peekskill Districts) PO Box 5205 Binghamton, NY 13902-5205 | 100 Broadway Menands ALBANY 12241 | State Office Building 44 Hawley Street BINGHAMTON 13901 | 295 Main Street Suite 400 BUFFALO 14203 | 130 Main Street W. ROCHESTER 14614 | 935 James Street SYRACUSE 13203

COVER SHEET - APPLICATION FOR BOARD REVIEW

WCB Case Number(s)	Carrier Case Number(s)	Carrier Code	Carrier's Name	Date of Injury
G0477983	W847008	0846-12-02699	City of Newyork N.Y.C.	11/01/2006

Claimant's Name	Address
Benjamin Holmes	P. O. Box 764 Bronx N.Y 10469

TO THE APPLICANT: This Application for Board Review may be filed with the Board by fax (1-877-533-0337; see Subject No. 046-144), e-mail (wcbclaimsfiling@wcb.ny.gov); see Subject Nos. 046-144 and 046-375), personal delivery to a Board District Office, or by mailing to one of the Board addresses listed at the top of this page. A copy of this Application must be served on all parties in interest. Sections 1 and 2 on the reverse side of this form must be completed. The failure to supply all information requested by this form may result in dismissal of the Application. If an additional attorney fee is being requested, Form OC-400.1 must be attached and served on all parties. For Applications filed by a carrier, TPA or self-insured employer, an up-to-date Form C-8/8.6 must be attached and served on all parties.

TO ALL OTHER PARTIES: Any Rebuttal to this Application must be served on the Board within 30 days following the date on which the Application was served on the parties, as specified in Section 2 on the reverse side of this form.

1. This application is made on behalf of:
☒ Claimant ☐ Employer/Carrier Benjamin Holmes (name) ☐ Special Funds ☒ Uninsured Employers' Fund
☐ Attorney/Licensed Representative

2. This application is made for: (choose only one)
☒ Review of WCLJ Decision (WCL § 23 and 12 NYCRR 300.13)
☒ Rehearing or Reopening (12 NYCRR 300.14)

3. The filing date of the decision which is the subject of this application is: 11/28/2012 Juge William Dugan

4. The remedy sought is:
☒ Administrative Correction of Decision ☐ Modification of the Decision
☐ Reversal of the Decision ☐ Rescission of the Decision

5. This application arises from an expedited hearing: ☒ Yes ☐ No

6. Specify the issue(s) for review:

☐ Employer/employee relationship	☐ Average Weekly Wage	☐ Special Funds Liability
☐ Accident	☒ Authorization of Treatment	☐ Attorney/Licensed Representative Fee
☐ Occupational Disease	☒ Period of Disability	☐ Facial Award
☐ Notice	☐ Degree of Disability	☐ Section 32 Denial
☐ Causal Relationship	☐ Reimbursement	☒ Disability Benefits
☐ Death Benefits	☒ Penalty	☐ Discrimination
☐ Timely Claim Filing	☐ WCL § 114-a Disqualification	☐ Policy Coverage
☐ Jurisdiction	☒ Apportionment	☐ ATF Deposit

7. Specify the grounds for review (foundation, basis, or points) relied upon in raising the issues identified above.
To whoit my Concearn I Benjamin Holmes asking For a hearing because of my lawer did not know How to Read the Doctor notatiop I went to the Montefiore Hospital to highlight all of the information I have all of that information that I got Sick on the Job this is why I ame asking For a hearing I ame willen to Provide this information to the Juge.

8. Make reference to the record below, or such part thereof, as is relevant to the issue(s) and ground(s) raised in this application. Also, indicate when and where such issue(s) and ground(s) were raised before the Workers' Compensation Law Judge.

Hearings (if minutes are not transcribed, so indicate):

Documents: provide name and document ID number:

NOTICE OF WORKERS COMPENSATION HEARING

State of New York
WORKERS' COMPENSATION BOARD

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board 215 W. 125th Street, 4th Floor New York, NY 10027	21	10/10/2012	9:00 AM 15 Min	NYC (800) 877-1373
	WCB Case No.		Date of Accident	WCB Home Page
	G0477983		11/01/2006	www.wcb.ny.gov
			Carrier ID No.	Carrier Case No.
			W847008	0846-12-02699
			CLAIMANT	
			Benjamin Holmes	

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

CLAIMANT: Bring this notice with you. Read important information on reverse side.

EMPLOYER NYC Parks & Recreation

CARRIER City of New York
c/o NYC Law Dept

COPIES TO Benjamin Holmes
Joseph A. Romano Law Offices

NOTICE OF PRELIMINARY HEARING:

See reverse side for important information about this preliminary hearing. Both Claimant and carrier are to be present prepared to furnish the information described on reverse side in order to fix a date for trial hearing. On the date set for trial hearing, the case will be decided on the evidence presented. There will be no further adjournment at that time except for good and sufficient cause.

PURPOSE OF HEARING:

Production of medical evidence.

EVIDENCE TO BE PRODUCED:

By Claimant: Claimant to produce medical.

IMPORTANT INFORMATION FOR THE CLAIMANT:

In a compensable workers' compensation case, bills for related medical treatment are the responsibility of your own employer or its workers' compensation insurance carrier. If you have used a private health insurance policy (Blue Cross, Blue Shield, G.H.I., H.I.P., or other) for payment of any bills in your workers' compensation case, please advise the private health insurer immediately.

In order to be reimbursed for any payments or co-payments you may have made for treatment or services which are the responsibility of the workers' compensation insurance carrier, you must tell the judge at this hearing about this payment.

THE NEW YORK STATE WORKERS' COMPENSATION BOARD PROHIBITS VISITORS, EMPLOYEES, CLIENTS OR WITNESSES FROM CARRYING OR BEARING FIREARMS OR ANY OTHER WEAPON ON BOARD PREMISES.

Dated: 09/24/2012

EC-16 (6/99) 17
(69)41853673-1

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

Robert E. Beloten
Chair

ADMINISTRATIVE REVIEW DIVISION
WORKERS' COMPENSATION BOARD
328 STATE STREET
SCHENECTADY, NY 12305
www.wcb.ny.gov

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

MEMORANDUM OF BOARD PANEL DECISION

keep for your records

Opinion By: David R. Dudley
Richard A. Bell
Linda Hull

The claimant's attorney requests review of the Workers' Compensation Law Judge (WCLJ) decision filed on December 3, 2012. The claimant has filed a pro se application for review. The self-insured employer, the City of New York (City), has filed a rebuttal.

ISSUES

The issues presented for administrative review are:

1. whether the claim is barred by Workers' Compensation Law (WCL) §18.

2. whether the claim is barred by WCL § 28.

FACTS

This is a controverted claim for chest pain. The claimant was employed by the City as a job training participant. The initially alleged date of injury was November 1, 2006.

In a C-3 form (Employee Claim for Compensation) filed on June 3, 2010, the claimant asserted that he had pain in his chest while working for New York City Parks and Recreation on

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision–	12/16/2013

ATENCION:
Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

November 1, 2006. On the form, the claimant indicated that his first treatment was on December 29, 2004.

The City filed a C-7 form (Notice that Right to Compensation is Controverted) contending that there was no accident and no medical evidence supporting a causal relationship. Further, the City raised the following issues: accident/occupational disease within the meaning of the WCL; accident/occupational disease arising out of and in the course of employment; notice (WCL § 18); and timely filing (WCL § 28).

The claimant filed a C-3 form on July 25, 2012, asserting that there was an injury on May 27, 2006 and that the claimant experienced chest pain.

At a hearing held on November 28, 2012, the claimant's attorney noted that, while the medical records in the file do not specifically reference an injury that occurred at work, the entire medical file should be accepted as prima facie medical evidence (PFME). The WCLJ found no PFME.

In a decision filed on December 3, 2012, the WCLJ disallowed the claim, finding that the claim is barred by WCL § 18 and WCL § 28.

LEGAL ANALYSIS

In the application for review, the claimant's attorney asserts that WCL § 28 was waived because an "advance compensation" was made by the claimant's employer prior to the expiration of the two year statute of limitations. The City paid wages in recognition of the claimant's injuries. The claimant's attorney contends that the claimant went home during the workday and notified the employer, and that the claimant was paid for the entire day. The claimant notes that he did not have an opportunity to testify on the issue of WCL § 28, and therefore the WCLJ's decision should be rescinded and the matter returned for further development of the record on the issue of WCL § 28.

The claimant filed a pro se application for review, dated December 26, 2012, on December 31, 2012. The claimant requests a hearing because his lawyer "did not know how to read the Doctor notation." The claimant indicates that he has information that he got sick on the job and is willing to provide the information to the WCLJ.

In rebuttal, the City contends that the application for review should be denied because it was not properly served on all parties on the same date. Further, the claimant has not appealed the

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision–	12/16/2013

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

EBRB-1 (4/99)
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disallowance of the claim under WCL § 18, and the City asserts that, since the claimant has not taken issue with the finding of WCL § 18, the appeal regarding WCL § 28 is moot. The City notes that the initial C-3 form alleged that the accident occurred on November 1, 2006, the revised C-3 form alleged that an accident occurred on May 27, 2006, and the claimant's medical indicates that the accident occurred in December 2006. The City asserts that, even using the date most favorable to the claimant, the C-3 form dated June 3, 2010 was filed nearly four years late. The claimant alleges an advanced payment of compensation as a defense for WCL § 28 for the first time on appeal, and it was never raised at any of the prior hearings. The City contends that the claimant waived the right to raise such a defense. The City has submitted timesheet records that show that the claimant did not miss any work on the alleged date of accident.

WCL § 18

"Workers' Compensation Law § 18 requires claimants seeking benefits to provide their employers with written notice of a compensable injury 'within thirty days after the accident causing such injury' (*see Matter of Miner v Cayuga Correctional Facility*, 14 AD3d 784 [2005]) ... Failure to provide such notice bars any claim, unless the Board excuses that failure on the ground that notice could not be given, the employer or its agent had knowledge of the accident, or the employer was not prejudiced (*see* Workers' Compensation Law § 18). The Board is not required to excuse a claimant's failure to give timely written notice even if one of these grounds is proven; the matter rests within the Board's discretion" (*Matter of Dusharm v Green Is. Contr., LLC*, 68 AD3d 1402 [2009]). When it is alleged that prompt oral notice was provided to the employer or to the employer's agent, "'resolution of the sufficiency of a claimant's oral notice is a matter within the exclusive province of the Board'" (*id. quoting Matter of Pisarek v Utica Cutlery*, 26 AD3d 619 [2006]). If a lack of prejudice to the employer is asserted, 'a claimant bears the burden of demonstrating that the employer was not prejudiced by any delay' (*Matter of Flynn v Ace Hardware Corp.*, 38 AD3d at 1144; *see Matter of Miner v Cayuga Correctional Facility*, 14 AD3d at 785; *Matter of Dempster v United Parcel Serv.*, 280 AD2d at 723)" (*Matter of Ewool v Franklin Hosp. Med. Ctr.*, 43 AD3d 1019 [2008], *lv denied* 10 NY3d 711 [2008]).

In this case, the Board Panel notes that the claimant did not provide written notice within 30 days of the alleged accident. The Board Panel further finds that the claimant failed to demonstrate the applicability of any of the three grounds to excuse late notice under WCL § 18.

Therefore, the Board Panel finds, upon review of the record and based on a preponderance of the evidence, that the WCLJ appropriately found that the claim is barred by WCL § 18.

WCL § 28

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision–	12/16/2013

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

Pursuant to WCL § 28, a claim for compensation will be barred unless the claim is filed with the Board within two years of the accident date.

Under WCL § 28, remuneration or payments by an employer or its carrier in the form of wages, medical treatment, or other compensable expenses constitute advance payments that trigger the exception to the two-year claim-filing requirement, provided that the payments were made in recognition or acknowledgment of liability under the Workers' Compensation Law (*see Matter of Schneider v Dunkirk Ice Cream*, 301 AD2d 906 [2003]). When payments are made without regard to the cause of injury, there can be no finding of advance payment (*see Matter of Kaschak v IBM Corp.*, 256 AD2d 830 [1998]).

In this case, the claim was filed more than four years late. The claimant raises an advanced payment of compensation as a defense to WCL § 28. The City submitted timesheet records that show that the claimant did not miss any work on the alleged date of accident.

The Board Panel finds the claimant's allegation of an advanced payment of compensation to be without merit. The Board Panel finds that the claimant has not met his burden of showing that the employer made an advance payment of compensation in recognition of its liability for his injury at work. The claimant does not have sufficient evidence of the employer's advanced payment of compensation.

Therefore, the Board Panel finds, upon review of the record and based on a preponderance of the evidence, that the claimant has not met his burden of showing that the employer made an advanced payment of compensation; that the claim is barred by WCL § 28; and that the claim was properly disallowed.

CONCLUSION

*** *Continued on next page* ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
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ATENCION:

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ACCORDINGLY, the WCLJ decision filed on December 3, 2012 is AFFIRMED. No further action is planned at this time.

All concur.

David R. Dudley

Richard A. Bell

Linda Hull

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
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ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

Copies To:	Case #G047 7983
Claimant:	Benjamin Holmes
Carrier:	City of NY Other Than Ed, High
Employer:	NYC Parks & Recreation
Other:	Joseph A. Romano Law Offices

Please see below for Recipients.

Benjamin Holmes
PO Box 764
Bronx, NY 10469

NYC Parks & Recreation
24 West 61st St
New York, NY 10023

City of NY Other Than Ed, High
Ed, Water Sup, Hlth & Hospital
Workers' Compensation Division
350 Jay Street, 9th Floor
Brooklyn, NY 11201

Joseph A. Romano Law Offices
703 Yonkers Avenue
Yonkers, NY 10704

EBRB-1 (4/99)
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OVER

Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

PATIENT'S NAME: HOLMES, Benjamin
MR NUMBER: 01287053
SURGEON'S NAME: JOSEPH DEROSE, M.D.
DATE OF SURGERY: 06-05-2007
TYPE OF REPORT: OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS:	Mitral Regurgitation
POST-OPERATIVE DIAGNOSIS:	same
OPERATION:	Mini-mitral valve replacement
SURGEON:	Joseph J. DeRose, Jr., MD
ASSISTANT:	Joseph Rabin, MD

PATHOLOGY: The patient is a 54 year-old man with a PMHx of HTN and a strong family history of CAD who was admitted to the hospital 3 weeks ago with chest pain and SOB. Echocardiogram revealed severe MR with a restricted anterior leaflet consistent with prior rheumatic disease. Cardiac catheterization revealed no evidence of CAD and confirmed the MR with moderate pulmonary hypertension. At operation the anterior leaflet was forshortened and scarred. The commissures were fused and the posterior leaflet was likewise restricted. Mitral Valve Replacement: 25/33 ON-X (mechanical)

POCEDURE: After the induction of general double lumen endotracheal anesthesia, the patient was positioned in an anterolateral thoracotomy position with the right arm supported on a pillow over the head. The chest and groins were prepped and draped in the usual sterile manner.

A 5 cm anterolateral thoracotomy incision was made in the 5th interspace. The pericardium was opened and suspended with pericardial sutures. Next a small incision was made in the right groin and the femoral artery and femoral vein were dissected free. ACT guided heparinization was then administered and the femoral artery was cannulated via a Sledinger technique with a 20 Fr Fem-Flex cannula. Next the femoral vein was cannulated with a 22 Fr Cardiovations cannula which was passed to the SVC/RA junction under echo guidance.

An antegrade cardioplegia cannulae was inserted into the aorta. Cardiopulmonary bypass was initiated. Sonnengard's groove was dissected. A Chitwood clamp was inserted through the axilla and after

Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

PATIENT'S NAME: HOLMES, Benjamin
MR NUMBER: 01287053
SURGEON'S NAME: JOSEPH DEROSE, M.D.
DATE OF SURGERY: 06-05-2007
TYPE OF REPORT: OPERATIVE REPORT

DICTATED BY: JOSEPH DEROSE, M.D.

JOSEPH DEROSE, M.D.

D: 06/12/2007 T: 06/13/2007 PMC/JA J: 19701 DT:6:02 PM
A: 162893440
Page 3 of 3
Authenticated and Edited by Joseph J Derose, MD On 6/14/07 9:23:53 AM

LAW OFFICES OF JOSEPH A. ROMANO
20 SOUTH BROADWAY
YONKERS, NY 10701
PHONE: (914) 965-1515
FAX: (914) 965-0410

Joseph A. Romano
Antonio Otero
Joju J. Thomas

January 20, 2009

Dear Client,

Please be advised that besides Worker's Compensation and Accident Cases, our firm also specializes in Social Security Disability and SSI claims. If you are currently out of work due to a Worker's Compensation claim or any other reason , you may qualify to apply for Social Security Disability or SSI benefits. If you would like to apply for any of these benefits, feel free to contact our office Monday to Friday 9:00AM to 8:00PM for a free consultation and procedures to apply.

Sincerely,

Joseph A Romano Esq.
Law Offices of Joseph A Romano

JAR/ym

Lynne S. Beccaro*
Andrew E. Berman**
Nicholas P. DeMeo
Nicholas N. DiSalvo
Jose M. Grajales
Bernard Han

The Law Offices of Joseph A. Romano

703 Yonkers Avenue Yonkers, NY 10704
420 Lexington Avenue Ste.626 New York, NY 10170
• Phone 914.965.1515 • 212.661.5886
• Fax 914.965.0410 • 212.661.5887
www.winningatlaw.com
• Toll Free 855.965.1515

David Hom
Benai Lifshitz
Anthony Brooks-Morgese
Antonio J. Otero
Joju J. Thomas***
Dan L. Wugman

* Member in NY and CT Bars
** Member in NY and NJ Bars
*** Member in NY and MA Bars

October 18, 2013

Workers' Compensation Board
P.O. Box 5205
Binghamton, NY 13902-5205
ATTN: Review Bureau

Claimant:	Benjamin Holmes
Employer:	New York City Department of Parks and Recreation
Carrier:	NYC Law Dept. Workers Compensation Division
Case#:	0846-12-02699
WCB#:	G0477983
DOA:	05/27/2006
Firm ID #:	481607

Honorable Commissioners:

Please be advised our office represents the above-mentioned claimant. Please provide us with the status of the outstanding Application for Board Review.

Should you have any concerns or require further information please do not hesitate to contact our office.

Respectfully,
Law Offices of Joseph A. Romano
JAR/lp

Lisa Potenza
Phone: 914-965-1515 Ext. 2610
Direct Fax: 914-355-3337
E-MAIL: lisa@romanolegalservices.com

CC: Benjamin Holmes

City of New York
Parks & Recreation

The Arsenal
Central Park
New York, New York 10021

Adrian Benepe
Commissioner

Arsenal West
24 West 61st Street
New York, New York 10023

David Terhune
Director of Personnel

(212) 830-7851
david.terhune@parks.nyc.gov

October 16, 2006

Benjamin Holmes

Dear Benjamin Holmes:

Thank you for your dedicated service to the New York City Department of Parks and Recreation. We hope that you have found your seasonal employment both educational and rewarding. As you are already aware, your temporary position with our agency will end on 11/18/2006. This information has already been given to the Human Resources Administration (HRA) for the purpose of rebudgeting or restoring your public assistance case. You do not need to give this information to HRA at this time.

If you have not yet secured permanent employment you must apply for Unemployment Insurance Benefits by calling (888) 209-8124 after your last day of work. Failure to apply for unemployment insurance if you are eligible may jeopardize your eligibility for public assistance. HRA will call you into a Job Center to receive an employment assessment and appropriate work activities that will be determined upon discussion with you and the Worker at your Job Center appointment. HRA will require you to bring proof of your application for UIB to your call-in appointment. You will receive a separate notification from HRA for this interview. If you have obtained unsubsidized employment, please bring documentation regarding your new job, such as a letter of employment and/or paystub, to this interview. Should you have any questions concerning your public assistance case, call HRA at (212) 643-2881 x269.

Again, many thanks for your service and best of luck in your future efforts.

Sincerely,

David Terhune
Director of Personnel

cc: Seth Diamond

F.E.G.S
HEALTH AND HUMAN SERVICES SYSTEM

Behavioral and Health Related Services
We Care Program. 5 FL
2432 Grand Concourse, Bronx, NY 10458

TEL: 718.741.7100
FAX: 718.220.1787
WEB: www.fegs.org

TODAY'S DATE: 1/22/07

CONFIRMATION OF SSI/SSD CASE STATUS

CLIENT'S NAME: Benjamin Holmes
HRA NUMBER: 2185592-01
SOCIAL SECURITY NUMBER: 100-48-3996
DATE FILED FOR SSI/SSD/APPEAL: 7/14/05
CASE STATUS: IS in Appeals

To Whom It May Concern,

This letter is to inform you, the above individual previously applied for SSI/SSD Federal Benefits and/or filed an Appeal in 7/14/05.
His/her SSI/SSD case status is currently In Process of Appeals
If you have any question, please feel free to contact me.

Sincerely,

Frances Byers – Entitlement Case Manager Specialist
(718) 741-7146

New York State Office of Temporary and DisabilityAssistance
Division of Disability Determinations
PO BOX 9009
ENDICOTT NY 13761-9009

(607)741-4041 Toll Free: 1-800-522-5511 Fax: 1-866-799-9182
www.OTDA.State.NY.US/DDD

05/31/05

BENJAMIN HOLMES
762 E 211TH ST PH
BRONX NY 10467

SSN 100-42-3996

On 05/02/05 we wrote to explain that this office is responsible for obtaining information in connection with the above named individual's application for Social Security benefits.

WE HAVE NOT RECEIVED YOUR COMPLETED WORK HISTORY REPORT AND DAILY ACTIVITIES FORM WHICH WE MAILED TO YOU ON 5/2/05. THIS INFORMATION IS IMPORTANT TO YOUR CLAIM FOR SOCIAL SECURITY DISABILITY BENEFITS AND CHECKS.

If we do not hear from you by 06/10/05 a decision may be made based on the information currently in the file.

If you require assistance or have any questions, please contact me at the telephone number above.

Si ud no habla Ingles, por favor obtenga alguna persona que hable Ingles para que pueda llamarnos de parte suya.

Sincerely yours,
D FREEMAN ext 4041
Disability Analyst - Unit A001

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): G0123585

A. YOUR INFORMATION (Employee)

1. Name: Benjamin (First) — (MI) Holmes (Last) 2. Date of Birth: 04/19/53
3. Mailing address: P.O. Box 764 (Number and Street/PO Box) Bronx (City) N.Y. (State) 10469 (Zip Code)
4. Social Security Number: 100-42-3996 5. Phone Number: (917) 9774738 6. Gender: ☒ Male ☐ Female
7. Do you speak English? ☒ Yes ☐ No If no, what language do you speak? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: New York Parks & Recreation 2. Phone Number: (___) _____
3. Your work address: 24 West 61 Street (Number and Street) Newyork (City) N.Y. (State) 10023 (Zip Code)
4. Date you were hired: 5/18/06 5. Your supervisor's name: Perez Shea
6. List names/addresses of any other employer(s) at the time of your injury/illness: _____
7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☒ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? J.T.P. - J.T.P.
2. What types of activities did you normally perform at work? Cut Grass
3. Was your job? (check one) ☐ Full Time ☐ Part Time ☒ Seasonal ☐ Volunteer ☐ Other: _____
4. What was your gross pay (before taxes) per pay period? 608.00 5. How often were you paid? _____
6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☒ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: 11/1/06 2. Time of injury: 12 ☐ AM ☒ PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____
4. Was this your usual work location? ☒ Yes ☐ No If no, why were you at this location? _____
   Went Home with Pain in my Chest
5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) Cuting Grass
   Went Home with Pain in my Chest.
6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____
7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: Benjamin (First) (MI) Holmes (Last) DATE OF INJURY/ILLNESS: / /

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☒ No
If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☒ Yes ☐ No
If yes, notice was given to: Perez Shea ☐ orally ☐ in writing Date notice given: 11/1/06

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☒ Yes, on what date? 12/28/06 ☐ No, skip to Section F.

2. Have you returned to work? ☐ Yes ☒ No If yes, on what date? / / ☐ regular duty ☐ limited duty

3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed

4. What is your gross pay (before taxes) per pay period? $400 a Week How often are you paid? Every 2 weeks

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? 12/29/04 ☐ None received (skip to question F-5)

2. Were you treated on site? ☐ Yes ☒ No

3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☒ Emergency Room
☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
Name and address where you were first treated: MonteFiore 111 East 210 Street
Bronx New York 10467 Phone Number: (718) 920 2273

4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
Give the name and address of the doctor(s) treating you for this injury/illness: Joseph J. DeRose Jr. MD
1575 Blondell Ave. Bronx NY. 10461 Phone Number: (718) 405-8371

5. Do you remember having another injury to the same body part or a similar illness? ☒ Yes ☐ No
If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
_____
_____
_____

6. Was the previous injury/illness work related? ☐ Yes ☐ No
If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: / /

On behalf of Employee: _____ Print Name: _____ Date: / /

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: / /

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: / /

Instructions for Completing Form C-3, "Employee Claim"

Please complete this form and send it to your local Workers' Compensation Board district office (DO) to apply for workers' compensation benefits. The addresses are listed at the bottom of these instructions. If you need additional help in completing this form, contact the Workers' Compensation Board at **1-877-632-4996. You may also fill this form out online at: http://www.wcb.state.ny.us/**

If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

Item 1: Enter your full name, including first name, middle initial, and last name.
Item 2: Enter your date of birth in month/day/year format. Include the four digit year.
Item 3: Enter your mailing address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Enter your Social Security Number. This is very important to help service your claim faster.
Item 5: Indicate the primary contact phone number, including area code. This may include a cell phone number.
Item 6: Indicate your gender (Male or Female).
Item 7: Check Yes if you can speak and understand English. If not, then check No and indicate which language you speak.

Section B - Your Employer(s):

Item 1: Indicate the employer you were working for at the time you were injured or became ill.
Item 2: Enter the phone number for this employer, either a primary contact number or the number for your supervisor.
Item 3: Enter the employer's address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Indicate the date you were hired by this employer.
Item 5: Enter your direct supervisor's name, whom you report to on a regular basis.
Item 6: If you have more than one job, please indicate the names and addresses of all other employers you work for besides the one you were injured at. Please attach a separate sheet if you need more room.
Item 7: Check Yes if you lost time from any of your other jobs as a result of your injury or illness; otherwise, check No.

Section C - Your Job on the Date of the Injury or Illness:

Item 1: Indicate your current job title or job description (e.g., warehouse worker).
Item 2: Indicate your typical work activities for this job (e.g., keeping inventory, unloading trucks, etc.).
Item 3: Check the type of job you had.
Item 4: Enter your gross pay (before taxes) per pay period.
Item 5: Indicate how often you received a paycheck (weekly, bi-weekly, etc.).
Item 6: Indicate if you received any tips or lodging in addition to your regular pay. If you did, describe them.

Section D - Your Injury or Illness:

Item 1: Enter the date when you were injured or the first date you noticed you became ill. Enter the date in month/day/year format. Include the four digit year. If this is an illness or occupational disease, then skip item 2.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible. (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now.)
Item 8: Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate on what date you stopped working. If you have not stopped working, check No and skip to the next section.

Section E - Return to Work (cont):

Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)

Item 3: If you have returned to work, indicate who you are working for now.

Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.

Item 2: Check if you were first treated on the job for this injury or illness.

Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).

Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise check No.

Item 5: If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**

Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for "Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the appropriate WCB district office (DO) at the address listed below:

Albany DO - 100 Broadway-Menands, Albany NY 12241 (866) 750-5157 (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton,Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)
Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY13901 (866) 802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland,Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
Buffalo DO - 369 Franklin Street, Buffalo NY 14202 (866) 211-0645 (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)
Rochester DO - 130 Main Street West, Rochester NY 14614 (866) 211-0644 (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans,Seneca, Steuben, Wayne, Wyoming, Yates)
Syracuse DO - 935 James Street, Syracuse NY 13203 (866) 802-3730 (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga,Oswego,St. Lawrence)
Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC (800) 877-1373; in Hempstead (866) 805-3630; in Hauppauge (866) 681-5354; in Peekskill (866) 746-0552 (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)

Copies To:
Claimant: Benjamin Holmes
Carrier: State Insurance Fund
Employer: Louis Leon D/B/A
Other:

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

NOTICE TO INJURED WORKER

1. Any compensation due will be sent to you by check by the employer or insurance carrier.

2. Keep a careful record of the payments received in order that you may have evidence of payment or nonpayment in case of dispute.

3. Do not pay anything to anyone representing you. If you hire a lawyer or licensed representative, the fee will be set by a W.C.Law Judge. The fee will be deducted from your award and paid by separate check directly to the lawyer or licensed representative by the employer or the insurance carrier.

4. Except for Volunteer Firefighters' and Volunteer Ambulance Workers' claims, no lost wage benefits are paid for the first seven days of disability unless the disability extends beyond 14 days.

5. If your case was continued and the Judge directed that your benefits are to continue, the insurance company or self-insured employer must keep paying you until :

   (a) you have another hearing and the Judge stops or changes your benefits

   or

   (b) your employer or insurance company has evidence that you have returned to work at regular pay or a report from your doctor stating you have no disability and submits this evidence to the Workers' Compensation Board.

6. If you wish to apply for administrative review of any part or all of the Judge's decision, your application must be in writing and received by the Board within 30 days of the filing date of this decision. The filing date is on the other side of this form in the lower right-hand corner. You may deliver your application in person to the District office or send it by mail.

7. If you have any further questions, you may contact your district office by mail or by telephone. The address of your district office is:

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205

Phone Number: (866) 746-0552

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
100 BROADWAY – MENANDS
ALBANY, NY 12241-0005
1-800-353-3092

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

NOTICE OF REJECTION OF CLAIM FOR DISABILITY BENEFITS
AVISO DE RECHAZO DE RECLAMACION DE BENEFICIOS POR INCAPACIDAD
(Special Fund for Disability Benefits)

BENJAMIN HOLMES PO BOX 764 BRONX, NY 10469	Date: Claimant's SS No.:	January 8, 2010 XXX-XX-3996

You are hereby notified that your claim for Disability Benefits is rejected under the Disability Benefits Law for the reason(s) checked below:

First day of disability
Date claim filed

☐ 1. Your claim was not filed within 26 weeks after the date your disability commenced

☐ 2. Your claim was not filed within 30 days after the date your disability commenced. (See item 4 on reverse.)

- ☐ A. No benefits payable
- ☐ B. Payments are being made beginning two weeks prior to the date your claim was filed.

☐ 3. Benefits from the Special Fund are provided for the unemployed who become disabled while claiming Unemployment Insurance. Since you were not claiming and/or receiving Unemployment Insurance immediately prior to your disability, as required by law, you are not entitled to benefits from the Special Fund.
IF YOU CONTEST THE REJECTION OF YOUR CLAIM FOR THIS REASON, FORWARD TO US EVIDENCE THAT YOU WERE CLAIMING OR RECEIVING UNEMPLOYMENT INSURANCE BENEFITS. THIS EVIDENCE MAY BE OBTAINED FROM YOUR LOCAL UNEMPLOYMENT INSURANCE OFFICE.

☐ 4. Disability Benefits are payable only for disabilities which commence within the first twenty-six weeks following termination of employment. The information in your claim indicates that your disability commenced more than twenty-six weeks after the termination of your last employment.

Last Day Worked ___ 26 Weeks Ended ___ Disability Began

☐ 5. You have not complied with our requests for information necessary to process your claim. (See Item 7, below.)

☐ 6. The medical reports on file do not indicate you were totally disabled beyond the date you have already been paid Disability Benefits. Your claim is, therefore, rejected for the period beyond ___ . If you were still disabled after that date, submit additional medical evidence immediately.

X 7. Other: 1) INFORMATION CONTAINED IN YOUR CLAIM INDICATES THAT YOUR DISABILITY MAY HAVE RESULTED FROM AN ACCIDENTAL INJURY ARISING IN AND OUT OF THE COURSE OF EMPLOYMENT, OR FROM AN OCCUPATIONAL DISEASE. THE DISABILITY BENEFITS LAW PROVIDES THAT NO DISABILITY BENEFITS ARE PAYABLE FOR ANY PERIOD FOR WHICH WORKERS' COMPENSATION BENEFITS ARE PAID OR PAYABLE.
2) UNDER SECTION 206.1A ANY PERIOD FOR WHICH YOU ARE COLLECTING SOCIAL SECURITY DISABILITY BENEIFTS IS NOT PAYABLE. DUPLICATION OF BENEFITS IS PROHIBITED.
3) BE ADVISED TO REOPEN YOUR COMPENSATION CASE # G0123585 AND PURSUE.

TO CLAIMANT: READ IMPORTANT INSTRUCTIONS FOR REQUESTING REVIEW ON REVERSE OF THIS FORM.
AL (A LA) RECLAMANTE: LEA, EN EL REVERSO DE ESTA FORMA, INSTRUCCIONES IMPORTANTES PARA SOLICITAR REVISION.

I Talk with

DB-307 (3-04)

07/01/2011 08:19:48 AM PAGE 1/005 Fax Server

Received by WCB Fax on 7/1/2011 8:26:50 AM

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205

100 Broadway
Menands
ALBANY 12241

State Office Building
44 Hawley Street
BINGHAMTON 13901

295 Main Street
Suite 400
BUFFALO 14203

130 Main Street W.
ROCHESTER 14614

935 James Street
SYRACUSE 13203

COVER SHEET - REBUTTAL OF APPLICATION FOR RECONSIDERATION / FULL BOARD REVIEW

WCB Case Number(s)	Carrier Case Number(s)	Carrier Code	Carrier's Name	Date of Injury
0792 5837	33786765-167	W204002	The State Insurance Fund	7/30/1979

Claimant's Name	Address
Benjamin Holmes	PO Box 764, Bronx, NY 10469

TO THE SENDER: This Rebuttal of an Application for Reconsideration / Full Board Review may be filed with the Board by fax (1-877-533-0337; see Subject No. 046-144), e-mail (wcbclaimsfiling@wcb.state.ny.us; see Subject Nos. 046-144 and 046-375), personal delivery to a Board District Office, or by mailing to one of the Board addresses listed at the top of this page. A copy of this Rebuttal must be served on all parties in interest. Sections 1 and 2 on the reverse side of this form must be completed. The failure to supply all information requested by this form may result in dismissal of the Rebuttal.

1. This rebuttal is made on behalf of:
☐ Claimant ☒ Employer/Carrier The State Insurance Fund (name) ☐ Special Funds ☐ Uninsured Employers' Fund

2. This rebuttal is in response to an application for: (choose only one)
☐ Mandatory Full Board Review
☒ Discretionary Full Board Review

3. The application was served upon the above cited party on: 6/16/2011

4. The filing date of the Memorandum of Decision which is the subject of the application for Reconsideration / Full Board Review is: 1/26/2011

5. This rebuttal contends that the:
☒ Application for Reconsideration / Full Board Review should be denied.
☐ Memorandum of Decision should be administratively corrected to read: _____
☒ Memorandum of Decision should be affirmed in its entirety
☐ Memorandum of Decision should be modified as to: _____

6. As to the finding(s) of fact and/or conclusion(s) of law made in the decision, this rebuttal contends:
Panel's decision should be affirmed because claim is time-barred under WCL sec. 123. Statute's 18-year time limit starts from 1979 injury and eight-year limit starts from 1985 last payment: therefore 1999 application to reopen is too late and a further award cannot be made.

7. Does the record cited in the application constitute the full record for review?: ☐ Yes ☐ No

If Yes, do you rest on that record?: ☐ Yes ☐ No

If No, and you contend that the record cited in the application does **not** constitute the full record for review, provide below the additional hearings, documents, and transcripts in the WCB's electronic file that are relevant to the issue(s) and ground(s) raised in the application, were **not** cited on the application, and complete the record for review:

Hearings: provide date(s) where issue(s) was raised before the Workers' Compensation Law Judge and evidence presented pertaining to the issue(s) and ground(s) raised and document ID number if applicable. If hearing minutes have not been transcribed, so indicate:

Documents: provide name and document ID number:
Board notice that case was destroyed- ID 179303860; C-3 -ID 147487953

Robert E. Beloten
Chair

ADMINISTRATIVE REVIEW DIVISION
WORKERS' COMPENSATION BOARD
328 STATE STREET
SCHENECTADY, NY 12305
www.wcb.ny.gov

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

MEMORANDUM OF BOARD PANEL DECISION

keep for your records

Opinion By: David R. Dudley
Richard A. Bell
Linda Hull

The claimant's attorney requests review of the Workers' Compensation Law Judge (WCLJ) decision filed on December 3, 2012. The claimant has filed a pro se application for review. The self-insured employer, the City of New York (City), has filed a rebuttal.

ISSUES

The issues presented for administrative review are:

1. whether the claim is barred by Workers' Compensation Law (WCL) §18.

2. whether the claim is barred by WCL § 28.

FACTS

This is a controverted claim for chest pain. The claimant was employed by the City as a job training participant. The initially alleged date of injury was November 1, 2006.

In a C-3 form (Employee Claim for Compensation) filed on June 3, 2010, the claimant asserted that he had pain in his chest while working for New York City Parks and Recreation on

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision–	12/16/2013

ATENCION:
Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

disallowance of the claim under WCL § 18, and the City asserts that, since the claimant has not taken issue with the finding of WCL § 18, the appeal regarding WCL § 28 is moot. The City notes that the initial C-3 form alleged that the accident occurred on November 1, 2006, the revised C-3 form alleged that an accident occurred on May 27, 2006, and the claimant's medical indicates that the accident occurred in December 2006. The City asserts that, even using the date most favorable to the claimant, the C-3 form dated June 3, 2010 was filed nearly four years late. The claimant alleges an advanced payment of compensation as a defense for WCL § 28 for the first time on appeal, and it was never raised at any of the prior hearings. The City contends that the claimant waived the right to raise such a defense. The City has submitted timesheet records that show that the claimant did not miss any work on the alleged date of accident.

WCL § 18

"Workers' Compensation Law § 18 requires claimants seeking benefits to provide their employers with written notice of a compensable injury 'within thirty days after the accident causing such injury' (*see Matter of Miner v Cayuga Correctional Facility*, 14 AD3d 784 [2005]) ... Failure to provide such notice bars any claim, unless the Board excuses that failure on the ground that notice could not be given, the employer or its agent had knowledge of the accident, or the employer was not prejudiced (*see* Workers' Compensation Law § 18). The Board is not required to excuse a claimant's failure to give timely written notice even if one of these grounds is proven; the matter rests within the Board's discretion" (*Matter of Dusharm v Green Is. Contr., LLC*, 68 AD3d 1402 [2009]). When it is alleged that prompt oral notice was provided to the employer or to the employer's agent, "'resolution of the sufficiency of a claimant's oral notice is a matter within the exclusive province of the Board'" (*id. quoting Matter of Pisarek v Utica Cutlery*, 26 AD3d 619 [2006]). If a lack of prejudice to the employer is asserted, 'a claimant bears the burden of demonstrating that the employer was not prejudiced by any delay' (*Matter of Flynn v Ace Hardware Corp.*, 38 AD3d at 1144; *see Matter of Miner v Cayuga Correctional Facility*, 14 AD3d at 785; *Matter of Dempster v United Parcel Serv.*, 280 AD2d at 723)" (*Matter of Ewool v Franklin Hosp. Med. Ctr.*, 43 AD3d 1019 [2008], *lv denied* 10 NY3d 711 [2008]).

In this case, the Board Panel notes that the claimant did not provide written notice within 30 days of the alleged accident. The Board Panel further finds that the claimant failed to demonstrate the applicability of any of the three grounds to excuse late notice under WCL § 18.

Therefore, the Board Panel finds, upon review of the record and based on a preponderance of the evidence, that the WCLJ appropriately found that the claim is barred by WCL § 18.

WCL § 28

*** Continued on next page ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision–	12/16/2013

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
180 LIVINGSTON STREET
BROOKLYN, NY 11248

ROBERT R. SNASHALL
CHAIRMAN

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

Date: AUG 0 2 1999

Benjamin Holmes
4110 Hill Avenue
Bronx, N.Y. 10466

WCB CASE NO.	CARRIER CASE NO.	CLAIMANT	EMPLOYER
07925837	—	HOLMES, B.	—

In accordance with your request, the above case [redacted]

was destroyed in our Albany Office. Once eighteen years have passed and nothing else is done with case, the file gets destroyed. Any questions, please feel free to contact us at (718) 802-6938. Thank you.

Joann Shelton
Director of Claims

By _____

718-802 6765

OC-650.1 (6-96)

8-9-2010

City of New York
Parks & Recreation

Arsenal West
24 West 61st Street
New York, New York 10023

Adrian Benepe
Commissioner

October 26th, 2006

To Whom It May Concern:

This is to confirm that Benjamin Flores attended the Parks Opportunity Program Job Fair on Thursday, October 26th, 2006. Please credit him/her for 8 hours.

If you have any further questions, please call me at 212-830-7754.

Sincerely,

Catherine Frangioni
Assistant Director
Marketing & Employment Services
Parks Opportunity Program

Katia Zaharieva
Assistant Director
Job Development
Parks Opportunity Program

Gal Lavid
Employment Specialist
Parks Opportunity Program

Jason Deo
Program Analyst
Parks Opportunity Program

SEPTEMBER 24 2018

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (If you know it): G 0123585

A. YOUR INFORMATION (Employee)

1. Name: Benjamin (First) — (MI) Holmes (Last) 2. Date of Birth: 04/19/53
3. Mailing address: P.O. Box 764 (Number and Street/PO Box) Bronx (City) NY. (State) 10469 (Zip Code)
4. Social Security Number: 100-42-3996 5. Phone Number: (917 977 4738 6. Gender: ☒ Male ☐ Female
7. Do you speak English? ☒ Yes ☐ No If no, what language do you speak? ____

B. YOUR EMPLOYER(S)

1. Employer when injured: New York Parks & Recreation 2. Phone Number: (___) ____
3. Your work address: 24 West 61 Street (Number and Street) Newyork (City) NY. (State) 10023 (Zip Code)
4. Date you were hired: 5/18/06 5. Your supervisor's name: Perez Shea
6. List names/addresses of any other employer(s) at the time of your injury/illness: ____
7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☒ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? J.T.P. - J.T.P.
2. What types of activities did you normally perform at work? Cut Grass
3. Was your job? (check one) ☐ Full-Time ☐ Part Time ☒ Seasonal ☐ Volunteer ☐ Other: ____
4. What was your gross pay (before taxes) per pay period? 608.00 5. How often were you paid? ____
6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☒ No If yes, describe: ____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: 11/1/06 2. Time of injury: 12 ☐ AM ☒ PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door): ____
4. Was this your usual work location? ☒ Yes ☐ No If no, why were you at this location? ____
Went Home with Pain in my Chest
5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) Cutting Grass
Went Home with Pain in my Chest.
6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) ____
7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): ____

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov

(877) 632-4996

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF PROPOSED DECISION

keep for your records

This decision makes legal findings about your on-the-job injury. It was made based on information in the Board's file as of this date.

The Findings section of this decision may state information such as what part of your body was injured; how much you were earning before you got hurt; how long you were out of work; whether you were entitled to be paid compensation benefits while you were out of work; the amount of weekly workers' compensation benefits; and if you have approval for medical treatment.

These legal findings are important and may limit your claim for workers' compensation benefits. If you DISAGREE with any part of this decision you must OBJECT. Write your objection on the back of this form and return it to the address listed above. The proposed decision will become FINAL on 8th day of July, 2014 so ANY OBJECTION to it must be RECEIVED by the Board BEFORE that date to be considered timely. Objections received on or after that date, will not be considered.

If you DO NOT UNDERSTAND this decision, you may contact the Board at 1-877-632-4996 for further information.

If you are not represented by legal counsel, you may want to consult an attorney or a licensed representative to assist you with your claim. An attorney or a licensed representative cannot charge you directly for representation in a workers' compensation case. If there is an award in your case, any legal fee request must be approved by the Board and will be deducted from the award to you by the insurance carrier and paid directly to the attorney or the licensed representative.

PROPOSED DECISION

FINDINGS: Form(s) C-8.1 which raised issues relating to treatment and/or disputed medical bills are resolved in favor of the carrier C-8.1B dated 3/21/14. Claim disallowed.

No further action is planned by the Board at this time.

*** *Continued on next page* ***

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of NY Other Than Ed, High
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision -	06/03/2014

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.ny.gov

(800) 877-1373

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G047 7983

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 11/28/2012 involving the claim of Benjamin Holmes at the Manhattan hearing location, Judge William Dugan made the following decision, findings and directions:

DECISION: Claim is disallowed.
Claim is barred by Sections 18 and 28.

Claimant's counsel notes exceptions.
. No further action is planned by the Board at this time.

Claimant -	Benjamin Holmes	Employer -	NYC Parks & Recreation
Social Security No. -		Carrier -	City of New York
WCB Case No. -	G047 7983	Carrier ID No. -	W847008
Date of Accident -	11/01/2006	Carrier Case No. -	0846-12-02699
District Office -	NYC	Date of Filing of this Decision–	12/03/2012

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

EC-23 (4/98)
FILE COPY

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205

100 Broadway
Menands
ALBANY 12241

State Office Building
44 Hawley Street
BINGHAMTON 13901

295 Main Street
Suite 400
BUFFALO 14203

130 Main Street W.
ROCHESTER 14614

935 James Street
SYRACUSE 13203

COVER SHEET - APPLICATION FOR BOARD REVIEW

WCB Case Number(s)	Carrier Case Number(s)	Carrier Code	Carrier's Name	Date of Injury
G0477983	W847008	0846-12-02699	City of New York N.Y.C.	11/01/2006

Claimant's Name	Address
Benjamin Holmes	P. O. Box 764 Bronx N.Y 10469

TO THE APPLICANT: This Application for Board Review may be filed with the Board by fax (1-877-533-0337; see Subject No. 046-144), e-mail (wcbclaimsfiling@wcb.ny.gov); see Subject Nos. 046-144 and 046-375), personal delivery to a Board District Office, or by mailing to one of the Board addresses listed at the top of this page. A copy of this Application must be served on all parties in interest. Sections 1 and 2 on the reverse side of this form must be completed. The failure to supply all information requested by this form may result in dismissal of the Application. If an additional attorney fee is being requested, Form OC-400.1 must be attached and served on all parties. For Applications filed by a carrier, TPA or self-insured employer, an up-to-date Form C-8/8.6 must be attached and served on all parties.

TO ALL OTHER PARTIES: Any Rebuttal to this Application must be served on the Board within 30 days following the date on which the Application was served on the parties, as specified in Section 2 on the reverse side of this form.

1. This application is made on behalf of:
☒ Claimant ☐ Employer/Carrier Benjamin Holmes (name) ☐ Special Funds ☒ Uninsured Employers' Fund
☐ Attorney/Licensed Representative

2. This application is made for: (choose only one)
☒ Review of WCLJ Decision (WCL § 23 and 12 NYCRR 300.13)
☒ Rehearing or Reopening (12 NYCRR 300.14)

3. The filing date of the decision which is the subject of this application is: 11/28/2012 Juge William Dugan

4. The remedy sought is:
☒ Administrative Correction of Decision ☐ Modification of the Decision
☐ Reversal of the Decision ☐ Rescission of the Decision

5. This application arises from an expedited hearing: ☒ Yes ☐ No

6. Specify the issue(s) for review:

☐ Employer/employee relationship	☐ Average Weekly Wage	☐ Special Funds Liability
☐ Accident	☒ Authorization of Treatment	☐ Attorney/Licensed Representative Fee
☐ Occupational Disease	☒ Period of Disability	☐ Facial Award
☐ Notice	☐ Degree of Disability	☐ Section 32 Denial
☐ Causal Relationship	☐ Reimbursement	☒ Disability Benefits
☐ Death Benefits	☒ Penalty	☐ Discrimination
☐ Timely Claim Filing	☐ WCL § 114-a Disqualification	☐ Policy Coverage
☐ Jurisdiction	☒ Apportionment	☐ ATF Deposit

7. Specify the grounds for review (foundation, basis, or points) relied upon in raising the issues identified above.
To Whoit my Concearn I Benjamin Holmes asking For a hearing because of my Lawer did not know How to Read the Doctor notation I went to the Montefiore Hospital to highlight all of the information I have all of that information that I got sick on the Job this is why I ame asking for a hearing I ame willen to Provide this information to the Juge.

8. Make reference to the record below, or such part thereof, as is relevant to the issue(s) and ground(s) raised in this application. Also, indicate when and where such issue(s) and ground(s) were raised before the Workers' Compensation Law Judge.

Hearings (if minutes are not transcribed, so indicate):

Documents: provide name and document ID number:

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (If you know it): G0123585

A. YOUR INFORMATION (Employee)

1. Name: Benjamin (First) — (MI) Holmes (Last) 2. Date of Birth: 04/19/53

3. Mailing address: P.O. Box 764 (Number and Street/PO Box) Bronx (City) N.Y. (State) 10469 (Zip Code)

4. Social Security Number: 100-42-3996 5. Phone Number: (917) 977 4738 6. Gender: ☒ Male ☐ Female

7. Do you speak English? ☒ Yes ☐ No If no, what language do you speak? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: New York Parks & Recreation 2. Phone Number: (___) _____

3. Your work address: 24 West 61 Street (Number and Street) New York (City) N.Y. (State) 10023 (Zip Code)

4. Date you were hired: 5/18/06 5. Your supervisor's name: Peret Shea

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☒ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? J.T.P. - J.T.P.

2. What types of activities did you normally perform at work? Cut Grass

3. Was your job? (check one) ☐ Full-Time ☐ Part Time ☒ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? 608.00 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☒ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: 11/1/06 2. Time of injury: 12 ☐ AM ☒ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door): _____

4. Was this your usual work location? ☒ Yes ☐ No If no, why were you at this location? _____

Went Home with Pain in my Chest

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) Cutting Grass

Went Home with Pain in my Chest

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

City of New York
Parks & Recreation

(15)

WEEK END. 5/27

Name Benjamin Holmes

ERN

Title JTP Reg Tour 7-330

Borough Bronx Dist 8

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S		EAL					
M		EAL					
T		AWOL					
W		AWOL					
T		AWOL					
F		RDO					
S		RDO					
			TOTALS		0		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S

TIME CARD NO. 9 REV. 11/03

City of New York
Parks & Recreation

WEEK END. 5/27/06

Name Holmes, Benjamin

ERN 3996

Title JTP Reg Tour 7-330

Borough BX Dist #2105

0333620 20805

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	700	1200	1230	330	8		
M		RDO					
T		RDO					
W	700	1200	1230	330	8		
T		PB					
F	700	1200	1258	330	8		
S	700	1200	1258	330	8		
			TOTALS		32		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8			8		8	8
8152	01						
8151							01

6/02

TIME CARD NO. 9 REV. 11/03

City of New York
Parks & Recreation

WEEK END. 6/10/06

0333620.

Name Benjamin Holmes

ERN

Title JTP Reg Tour 7X330

Borough Bronx Dist 11

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	700	1200	1230	330	8		
M		RDO					
T		RDO					
W	700	1200	1230	330	8		
T	700	1200	1230	330	8		
F	700	1200	1230	330	8		
S	700	1200	1230	330	8		
			TOTALS		40		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8			8	8	8	8
8152	01						
8151							01

6/16

TIME CARD NO. 9 REV. 11/03

City of New York
Parks & Recreation

WEEK END. 6/17

0333620

Name Benjamin Holmes

ERN 3996

Title JTP Reg Tour 7X330

Borough Bronx Dist 11

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	700	1200	1230	330	8		
M		RDO					
T		RDO					
W	700	1200	1230	330	8		
T	700	1200	1230	330	8		
F	700	12	1230	330	8		
S	700	12	1230	330	8		
			TOTALS		40		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8			8	8	8	8
8152	01						
8151							01

6/24

TIME CARD NO. 9 REV. 11/03

City of New York
Parks & Recreation

WEEK END.

week 25 6/18/2006 - 6/24/2006

Name HOLMES, BENJAMIN

ERN 0333620 CD- 0 BX21105

Job training participant 9110

Title Reg. Tour: 7X330

Borough

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	7	12	1230	330	8		
M			RDO				
T	7	12	1230	330	8		
W	7	12	1230	330	8		
T		RDO					
F	700	1200	1230	330	8		
S	200	1200	1230	330	8		
			TOTALS		40		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8		8	8		8	
8152	01						
8151							

6/28

TIME CARD NO. 9 REV. 11/03

City of New York
Parks & Recreation

WEEK END. _____

week 26 6/25/2006 - 7/1/2006

Name HOLMES, BENJAMIN
ERN 0333620 CD- 0 BX21105
Title Job training participant 9110
Reg. Tour: 7x330
Boro

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	700	1200	1230	330	8		
M	700	1200	1230	330	X	8	
T	700	1200	1230	330	8		
W	700	1200	1230	330	8		
T	700	12:00	1230	330	8		
F		RDO					
S	700	1200	1230	330	8		
			TOTALS		40	8	

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8		8	8	8		8
8152	01						
8151							01
NDS		8		adj 7/21			
1001							

TIME CARD NO. 9 REV. 11/03

City of New York
Parks & Recreation

WEEK END. _____

week 27 7/2/2006 - 7/8/2006

Name HOLMES, BENJAMIN
ERN 0333620 CD- 0 BX21105
Title Job training participant 9110
Reg. Tour: 7x330
Boro

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	700	1200	1230	330	8		
M		RDO					
T	700	1200	1230	330	8		
W	700	1200	1230	330	8		
T			RDO				
F	700	1200	1230	330	8		
S	7AM	12PM	1230	530	8		
			TOTALS		40		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8		8	8		8	8
8152	01						
8151							01
						7/13	

TIME CARD NO. 9 REV. 11/03

City of New York
Parks & Recreation

WEEK END. _____

week 28 7/9/2006 - 7/15/2006

Name HOLMES, BENJAMIN
ERN 0333620 CD- 0 BX21105
Title Job training participant 9110
Reg. Tour: 7x330
Boro

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	700	1200	1230	330	8		
M		RDO					
T		RDO					
W		AWOL					
T		AWOL					
F		AWOL					
S		AWOL					
			TOTALS		8		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8						
8152	01						
						7/19	

TIME CARD NO. 9 REV. 11/03

(5789)34546265-1

State of New York
WORKERS' COMPENSATION BOARD

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board **1 Larkin Plaza (Dock Street)** **Yonkers, NY 10701**	**2**	**09/16/2009**	**10:30 AM** **15 Min**	Peekskill (866) 746-0552
	WCB Case No.	07925837	Date of Accident	WCB Home Page
			07/30/1979	www.wcb.state.ny.us
			Carrier ID No.	Carrier Case No.
			W204002	050494331
			CLAIMANT	
			Benjamin Holmes	

RECEIVED
SEP 16 2009
NYS WORKERS' COMPENSATION BOARD
YONKERS CUSTOMER SERVICE CENTER

(Continued from Page 1)

who requests a cancellation, adjournment, or continuance.

C-7 issues.

IMPORTANT INFORMATION FOR THE CLAIMANT:

In a compensable workers' compensation case, bills for related medical treatment are the responsibility of your own employer or its workers' compensation insurance carrier. If you have used a private health insurance policy (Blue Cross, Blue Shield, G.H.I., H.I.P., or other) for payment of any bills in your workers' compensation case, please advise the private health insurer immediately.

In order to be reimbursed for any payments or co-payments you may have made for treatment or services which are the responsibility of the workers' compensation insurance carrier, you must tell the judge at this hearing about this payment.

Dated: 08/25/2009

EC-16 (6/99) 65
(5789)34546265-1

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

City of New York Parks & Recreation

WEEK END. _____

week 29 ~~7/16/2006~~ - 7/22/2006

Name HOLMES, BENJAMIN
ERN 0333620 CD- 0 BX21105
Title Job training participant 9110
Reg. Tour: 7X330
Borough

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	700	12	1230	330	8		
M		RDO					
T		RDO					
W	700	12	1230	330	8		
T	700	12	1230	330	8	5	
F	700	12	1230	330	8		
S	7	1200	1230	330	8		
			TOTALS		40	5	

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8			8		8	8
4293					8		
8152	01						
8151							01
1405		adj	7/28	5			
1002							

7/26

TIME CARD NO. 9 REV. 11/03

City of New York Parks & Recreation

WEEK END. _____

week 30 7/23/2006 - 7/29/2006

Name HOLMES, BENJAMIN
ERN 0333620 CD- 0 BX21105
Title Job training participant 9110
Reg. Tour: 7X330
Borough

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	700	1200	1230	330	8		
M		RDO					
T		RDO					
W	700	1200	1230	330	8		
T	700	12	1230	330	8		
F	700	1200	1230	1230	5		
S	7-	1200	1230	330	8		
			TOTALS		37		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8			8	8	5	8
8152	01						
8151							01

8/01

TIME CARD NO. 9 REV. 11/03

City of New York Parks & Recreation

WEEK END. _____

week 31 7/30/2006 - 8/5/2006

Name HOLMES, BENJAMIN
SS# 0333620 CD- 0 BX21105
Title Job training participant 9110
Reg. Tour: 7X330
Borough

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	7-	12	1230	330	8		
M			RDO				
T			RDO				
W			DiF				
T			POP		8		
F	700	12	1230	330	8		
S	700	1200	1230	330	8		
			TOTALS		32		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	8					8	8
8152	01						
4293					8		
8151							01

8/09

TIME CARD NO. 9 REV 2/93

City of New York Parks & Recreation

WEEK END. 6/3/06

0333620

Name Benjamin Holmes

ERN 100-42-3996

Title JTP Reg Tour 7-330

Borough BRONX Dist 11

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S	730	1200	1230	330	7½		
M	700	1200	1230	330	X	8	
T		R D O					
W	900	12PM	1230	330	8		
T	700	1230	1230	330	8		
F	700	1200	1230	330	8		
S	700	1200	1230	330	8		
			TOTALS		39½		

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100	7½			8	8	8	8
8152	01						
8151							01
1400		½					
1405		7½					1
1002		6/9/06					
						6/07	

TIME CARD NO. 9 REV. 11/03

City of New York Parks & Recreation

WEEK END. 5/20/06

Name Benjamin Holmes

ERN 100-42-3996

Title JTP Reg Tour 7-330

Borough BX Dist 11

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S							
M							
T							
W							
T							
F	700	12	1230	330	8		
S	730	1200	1230	330	7½		
			TOTALS		15½		

NEW START

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
0100						8	7½
8151							01
						5/26	

TIME CARD NO. 9 REV. 11/03

City of New York Parks & Recreation (18)

WEEK END. 5/20

Name Benjamin Holmes

ERN 3996

Title JTP Reg Tour

Borough BX Dist 8

0333620-0

	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	HOURS WORKED REG HRS	PD OT HRS	CT HRS
S							
M							
T							
W							
T	900	12PM	1230	3:30PM	5½		
F		EAL					
S		EAL					
			TOTALS		5½		

BX-10R

TIMEKEEPING USE ONLY

EVENT CODE	S	M	T	W	T	F	S
					5½		
						5/4	

TIME CARD NO. 9 REV. 11/03

(5790)34546825-1

NOTICE OF WORKERS COMPENSATION HEARING

State of New York
WORKERS' COMPENSATION BOARD

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board **1 Larkin Plaza (Dock Street)** **Yonkers, NY 10701**	**2**	**09/16/2009**	**10:30 AM** **15 Min**	Peekskill (866) 746-0552
	WCB Case No.		Date of Accident	WCB Home Page
	G0123585		07/30/1979	www.wcb.state.ny.us
			Carrier ID No.	Carrier Case No.
			W000004	

CLAIMANT
Benjamin Holmes

Benjamin Holmes
1160 Burke Ave
Bronx, NY 10469-5021

CLAIMANT: Bring this notice with you. Read important information on reverse side.

EMPLOYER Louis Leon

CARRIER *** Carrier Undetermined ***

07925837

COPIES TO Benjamin Holmes
Louis Leon
Joseph A. Romano Law Offices

PLEASE NOTE: THIS HEARING WILL BE HELD AT THE YONKERS CUSTOMER SERVICE CENTER. THE HEARINGS ARE HELD ON THE 2ND FLOOR. PHONE NUMBER: 1-866-746-0552. PLEASE BE PREPARED TO SHOW PHOTO IDENTIFICATION UPON ARRIVAL.

PURPOSE OF HEARING:

C-7 issues.

IMPORTANT INFORMATION FOR THE CLAIMANT:

In a compensable workers' compensation case, bills for related medical treatment are the responsibility of your own employer or its workers' compensation insurance carrier. If you have used a private health insurance policy (Blue Cross, Blue Shield, G.H.I., H.I.P., or other) for payment of any bills in your workers' compensation case, please advise the private health insurer immediately.

In order to be reimbursed for any payments or co-payments you may have made for treatment or services which are the responsibility of the workers' compensation insurance carrier, you must tell the judge at this hearing about this payment.

Dated: 08/25/2009

EC-16 (6/99) 345
(5790)34546825-1

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.state.ny.us

(866) 746-0552

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #0792 5837

NOTICE OF DECISION

keep for your records

Joseph Remono
914-965-1515

At the Workers' Compensation hearing held on 07/07/2010 involving the claim of Benjamin Holmes at the Yonkers hearing location, Judge Chaim Malks made the following decision, findings and directions:

DECISION: Disallowed as claimant has no evidence of a claim. If claimant obtains new evidence showing that liability was established or that the employer or a carrier paid benefits or medical bills he may apply to the Board for reopening. No further action is planned by the Board at this time.

I Benjamin Holmes wont to Appeal this Decision. becase of Judge Chaim Malks didnt answer my question I ask Him where did I get the WCB number From and the Carrier Number. I have paper From 1999 wend I ask to reoper my Workers Compensation Case. and I all so ask him if I get a notarize Latter From Leopold N Bonitto the other Partner. I need answer to my question.

Thank you
Benjamin Holmes
7-22-2010

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision -	07/12/2010

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

(5789)34546265-1

State of New York
WORKERS' COMPENSATION BOARD

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board **1 Larkin Plaza (Dock Street)** **Yonkers, NY 10701**	**2**	**09/16/2009**	**10:30 AM** **15 Min**	Peekskill (866) 746-0552
	WCB Case No.		Date of Accident	WCB Home Page
	07925837		07/30/1979	www.wcb.state.ny.us
			Carrier ID No.	Carrier Case No.
			W204002	050494331
			CLAIMANT	
			Benjamin Holmes	

(Continued from Page 1)

who requests a cancellation, adjournment, or continuance.

C-7 issues.

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In order to be reimbursed for any payments or co-payments you may have made for treatment or services which are the responsibility of the workers' compensation insurance carrier, you must tell the judge at this hearing about this payment.

Dated: 08/25/2009

EC-16 (6/99) 65
(5789)34546265-1

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. USE CLAIM FORM **DB-300** IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS.**
2. BE SURE TO COMPLETE ALL ITEMS OF PART A - THE **"CLAIMANT'S STATEMENT"**. BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. YOUR REPRESENTATIVE'S NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER** HAS COMPLETED ALL ITEMS IN PART B - THE **"HEALTH CARE PROVIDER'S STATEMENT."**

YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY** (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST PAID-FOR-HOURS INSURANCE COMPANY.

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

Social Security Number: 100 42 3996

1. My name is Benjamin (First) Holmes (Middle) (Last)
2. Address: P.O. Box 704 (Number, Street) Bronx (City or Town) NY (State) 10469 (Zip Code) (Apt. No.)
3. Tel. No. 917-971-4738 4. Date of Birth 4-19-53 5. Married (Check one) ☐ Yes ☒ No
6. My disability is (if injury, also state how, when and where it occurred) My disability Started on 7-30-99 Carpal tunnel up on a wall The Park Department Sent to work on 6/25/06 to 11-25-06
7. I became disabled on 7 (Month) 30 (Day) 99 (Year) a. I worked on that day ☐ Yes ☐ No
   b. I have since worked for wages or profit. ☐ Yes ☒ No If "Yes", give dates .....
8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT						AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			
			Mo.	Day	Yr.	Mo.	Day	Yr.	

9. My job is or was ..... (Occupation) ..... (Name of Union and Local Number, if Member)
10. For the period of disability covered by this claim
    a. Are you receiving wages, salary or separation pay: ☐ Yes ☒ No
    b. Are you receiving or claiming?
    (1) Workers' compensation for work-connected disability ☒ Yes ☐ No
    (2) Unemployment Insurance Benefits ☐ Yes ☒ No
    (3) Damages for personal injury ☒ Yes ☐ No
    (4) Benefits under the Federal Social Security Act for long-term disability ☒ Yes ☐ No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
    I have ☐ received ☐ claimed from N.A. for the period ..... (Date) to ..... (Date)
11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began ☐ Yes ☒ No
    If "Yes", fill in the following: I have been paid by State Disability Fund From 10-99 (Date) To 7-99 (Date)
12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Claim signed on 10-22-01 (Date) Benjamin Holmes (Claimant's Signature)

If signed by other than claimant, print below name, address, and relationship of representative.

.....

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A, Claimant's Authorization to have Form ... online. ...

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNÍQUESE CON LA OFICINA MÁS CERCANA DE LA JUNTA DE COMPENSACIÓN OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157 | State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604 | Statler Towers 107 Delaware Ave. BUFFALO 14202 (866) 211-0645 | 130 Main Street W. ROCHESTER 14614 (866) 211-0644 | 935 James St. SYRACUSE 13203 (866) 802-3730

WORKERS' COMPENSATION BOARD

AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ☒WCB ☐DB ☐Discrimination and/or Date of Accident
Benjamin Holmes	100-42-3996	0792 5837 / G0123585 7/30/79 / 5/25/06 / 11/25/06

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

[illegible] treatment for my [illegible] [illegible] [illegible] sent me back to work. WCB Case No G0123585

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:
Submit original to the Workers' Compensation Board and retain a copy for your records. ***Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.*** **This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.**
THIS AUTHORIZATION DOES NOT PERMIT eCASE ACCESS.

Pursuant to Section 110-a of the Workers' Compensation Law, I, Benjamin Holmes (Claimant's Name) represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

Park Department For 5/25/06 to 11/25/06 [illegible] Gulf Gas Station 7/30/79
Name of a Specific Person, Corporation, Association or Public or Private Entity

24 W 28st 61 N.Y. N.Y. 10023
Address
[illegible] 212 830-7823

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

Benjamin Holmes 12/22/09
(Claimant's Signature only) Date

[illegible] processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

State of New York
WORKERS' COMPENSATION BOARD

NOTICE OF PRE-HEARING CONFERENCE / HEARING

FILE COPY

Place of Conference	Part	Date of Conference	Time	District Office
Yonkers, NY	2	08/18/2009	1:00 PM 15 Min	Peekskill

WCB Case No.	Carrier ID No.	Carrier Case No.	Date of Accident	WCB Home Page
07925837	W204002	050494331	07/30/1979	www.wcb.state.ny.us

Benjamin Holmes
1160 Burke Ave.
Bronx, NY 10469

POIs not sent a notice
PE L. L. Gulf Gas Station

State Insurance Fund
105 Corporate Park Dr, Ste 200
White Plains, NY 10604-3814

*A0 Joseph A. Romano Law Offices
703 Yonkers Avenue
Yonkers, NY 10704

PLEASE NOTE: THIS HEARING WILL BE HELD AT THE YONKERS CUSTOMER SERVICE CENTER. THE HEARINGS ARE HELD ON THE 2ND FLOOR. PHONE NUMBER: 1-866-746-0552. PLEASE BE PREPARED TO SHOW PHOTO IDENTIFICATION UPON ARRIVAL.

The employer/carrier has objected to the claim for workers' compensation benefits by filing a Notice of Controversy (Form C-7). Because the employer/carrier objected to the claim, the claimant is not receiving any benefits. As compensation benefits are not being paid, the Board has scheduled a Pre-Hearing Conference with the parties.

The purpose of the Pre-Hearing Conference is to provide a mechanism for the identification of issues and relevant evidence and to permit the parties an opportunity to assess their case and to resolve outstanding issues prior to trial.

Ten days prior to the Pre-Hearing Conference, each party shall file with the Board a Pre-Hearing Conference Statement (Form PH-16.2). The parties should also bring two additional copies to the Pre-Hearing Conference. In cases where the claimant is not represented by counsel at the Pre-Hearing Conference, the claimant is not required to file the Pre-Hearing Conference Statement. If the claimant retains a legal representative within 10 days of the Pre-Hearing Conference, a Pre-Hearing Conference Statement must still be filed.

The claimant's and employer/carrier's statement shall be accompanied by any and all reports, forms and documents that the claimant or employer/carrier intends to use at the hearing(s), including hospital records and forms detailing the employer's statement of wages and the claimant's work status, except if the reports, forms or documents are already part of the Board's electronic case folder.

For claimants represented by counsel, an employee claim form (Form C-3) shall be accompanied by an attorney certification. Employers/carriers, or their legal representative, must file a written certification when the notice of controversy (C-7) is filed.

If as a result of the Pre-Hearing Conference an Initial Expedited Hearing is scheduled, any Independent Medical Examination (IME) Report shall be filed with the Board at least three days before the date set for the Initial Expedited Hearing. Failure to file and serve an IME Report shall be a waiver of the insurance carrier's right to examine the claimant and to have the IME Report considered on the threshold issue of causal relationship, unless the employer/carrier makes a showing of good cause for such failure, and that it acted in good faith and with due diligence.

Dated: 07/28/2009

1 PH-16.1 (11/08)

State of New York
WORKERS' COMPENSATION BOARD

FILE COPY

NOTICE OF PRE-HEARING CONFERENCE / HEARING

Place of Conference	Part	Date of Conference	Time	District Office
Yonkers, NY	2	08/18/2009	1:00 PM 15 Min	Peekskill

WCB Case No.	Carrier ID No.	Carrier Case No.	Date of Accident	WCB Home Page
07925837	W204002	050494331	07/30/1979	www.wcb.state.ny.us

Forms may be located at the Board's web site or by calling the nearest District office. Claimants who represent themselves may call the Advocate for Injured Workers at 1-800-580-6665 if they have questions about completing the forms.

CLAIMANT/ CLAIMANT'S REPRESENTATIVE: In addition, you must file with the Board or bring to the hearing, Both sides to produce all documentation, including past decisions, related to the 8/1/79 accident

INSURANCE CARRIER/ EMPLOYER: In addition, the insurance carrier/employer must file with the Board or bring to the hearing, Both sides to produce all documentation, including past decisions, related to the 8/1/79 accident

Dated: 07/28/2009

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

1 PH-16.1 (11/08)

City of New York
Parks & Recreation

The Arsenal
Central Park
New York, New York 10021

Adrian Benepe
Commissioner

Arsenal West
24 West 61st Street
New York, New York 10023

David Terhune
Director of Personnel

(212) 830-7851
david.terhune@parks.nyc.gov

October 16, 2006

Benjamin Holmes
762 East 211th Street
Bronx, NY 10467

Dear Benjamin Holmes:

Thank you for your dedicated service to the New York City Department of Parks and Recreation. We hope that you have found your seasonal employment both educational and rewarding. As you are already aware, your temporary position with our agency will end on 11/18/2006. This information has already been given to the Human Resources Administration (HRA) for the purpose of rebudgeting or restoring your public assistance case. You do not need to give this information to HRA at this time.

If you have not yet secured permanent employment you must apply for Unemployment Insurance Benefits by calling (888) 209-8124 after your last day of work. Failure to apply for unemployment insurance if you are eligible may jeopardize your eligibility for public assistance. HRA will call you into a Job Center to receive an employment assessment and appropriate work activities that will be determined upon discussion with you and the Worker at your Job Center appointment. HRA will require you to bring proof of your application for UIB to your call-in appointment. You will receive a separate notification from HRA for this interview. If you have obtained unsubsidized employment, please bring documentation regarding your new job, such as a letter of employment and/or paystub, to this interview. Should you have any questions concerning your public assistance case, call HRA at (212) 643-2881 x269.

Again, many thanks for your service and best of luck in your future efforts.

Sincerely,

David Terhune
Director of Personnel

cc: Seth Diamond
BX21105

MONTEFIORE

Burke Avenue
941 Burke Avenue Bronx, NY 10469
(718) 654-5900 Fax: (718) 654-0053

05/26/2010

Benjamin Holmes
Po Box 764 Apt# 3c
Bronx, NY 10469

To whom it may concern:

Benjamin Holmes is a patient in this office on coumadin for a metal valve placed 4/2007. He may not use pain medications containing the analgesic acetominophen and this medication will raise his anticoagulation levels and increase the chance of bleeding.

If you have any questions, please call us @ 718-654-5900. We appreciate being able to work with you.

Sincerely,

Joel Posner, MD

JOEL POSNER, M.D.
941 Burke Avenue
Bronx, NY 10469
(718) 654-5900 · Fax 654-0053

New York City
BRONX MUNICIPAL HOSPITAL CENTER
AFFILIATED WITH
ALBERT EINSTEIN COLLEGE OF MEDICINE
PELHAM PARKWAY SOUTH AND EASTCHESTER ROAD
BRONX, NEW YORK 10461

TO: TO WHOM IT MAY CONCERN

FROM: NUCLEAR MEDICINE DEPARTMENT
BRONX MUNICIPAL HOSPITL CENTER

RE: APPOINTMENT VERIFICATION

DATE: 3/10/05

NAME: Benjamin Holmes was seen in our laboratory

DATE: 3/10/05, for a nuclear medicine procedure.

If there are any questions, please call us. 918-4892/4894

Social Security Benefit Information

From: SOCIAL SECURITY ADMINISTRATION

Refer To: **100-42-3996 A**

3247 Laconia Ave
Bronx, NY 10469

Date: May 24 2010

BENJAMIN HOLMES
PO BOX 764
BRONX NY 10469-0702
ADDR UPDA ED 09/02/2009

Information about a person's Social Security benefits is confidential by law. Except under certain circumstances specified by law and regulations, the Social Security Administration does not reveal such information to any person except the beneficiary involved, or his or her authorized representative.

Attached is the information you requested about your benefits. The attachment is an official record of your Social Security and/or supplemental security income benefits as of the date of this letter. You may use the attached information for proof of benefits.

If you have any questions concerning this official record, please contact your local Social Security Office.

A Wilder
Manager

UNION HOSPITAL

Over Eighty Years of Service to the Bronx Community

260 EAST 188th STREET - BRONX, N.Y. 10458 (718) 220-2020 - 295-1700

Founded 1909

voluntary-supported
non-sectarian
fully accredited

Dear Sir or Madam

The visit date for the record you requested has exceeded the required retention period of
Six years for adults and age of majority plus the Statue of Limitations (2 ½ years civil cases; 3 years criminal cases) for minors (New York State Codes, Rules & Regulations 405, chapter 1). The records are no longer available.

Re: Benjamin Holmes - records from 1980.

Phyllis L. Astorino 4/28/10

Phyllis L. Astorino
Director, Health Information Administration Date

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
OFFICE OF GENERAL COUNSEL
20 PARK STREET
ALBANY, NY 12207

(518) 486-9564

DAVID A. PATERSON
GOVERNOR

ROBERT E. BELOTEN
CHAIR

April 22, 2010

Benjamin Holmes
P.O. Box 764
Bronx, New York 10469

Re: **Reference No. 10-77**

Dear Mr. Holmes:

I am in receipt of your undated letter, requesting your workers' compensation records, which was received by the Workers' Compensation Board's Office in Norwich on April 5, 2010, and forwarded to the Office of General Counsel for handling.

Please be advised that a search of our records has been conducted. I have identified 224 pages which relate to your request. Section 87 of the Public Officers Law authorizes an agency to request a fee of $.25 per page for copies of records. Accordingly, please forward payment of $56.00 via personal check, certified check, or money order (please do not send cash) payable to the New York State Workers' Compensation Board. Please forward payment with a copy of this letter to:

Darlene Thompson
New York State Workers' Compensation Board
Office of General Counsel
20 Park Street, Room 401
Albany, New York NY 12207

Upon receipt of the photocopying fee, the documents you requested will be forwarded to you. In the alternative, you may visit any district office or customer service center of the Workers' Compensation Board, and upon presenting photo identification, you may view your case file, and choose to pay for and print only those documents you need.

In all future correspondence relating to this request, please refer to the reference number as indicated above. Thank you.

Sincerely,

Darlene Thompson

Darlene Thompson
Administrative Assistant

City of New York
Parks & Recreation

Henry J. Stern
Commissioner

Ranaqua
Bronx Park
Bronx, New York 10462

William Castro
Borough Commissioner
Bronx

Date 10/15/96

Dear Benjamin Holmes:

This is to advise you that a paycheck is being held for you in the amount of $ 77.93.

In order for us to mail you the check, please fill out the information below and send this letter with a self-addressed stamped envelope to the Payroll Office at the above address.

If you prefer to pick up your check, you may come to the Bronx Borough Office between 9:00 a.m. and 4:00 p.m. Monday through Friday. Please bring this letter and a form of identification with you.

If we do not hear from you by 10/25/96, Your check will be returned to the Office of Payroll Administration.

Very truly yours,
Brenda Hinds
(718) 430-1810

Please fill out:

Name _____
Address _____
Social Security # _____

Please send my check: _____ Certified Mail
_____ Regular Mail

Ranaqua, the Bronx Borough Headquarters of the Department of Parks & Recreation of the City of New York, is located in the southeast part of Bronx Park, east of the northbound lanes of the Bronx River Parkway.

City of New York
Parks & Recreation

The Arsenal
Central Park
New York, New York 10021

Adrian Benepe
Commissioner

CIN # WD 86222A

Arsenal West
24 West 61st Street
New York, New York 10023

David Terhune
Director of Personnel

(212) 830-7851
david.terhune@parks.nyc.gov

October 16, 2006

Benjamin Holmes
~~762 East 214th Street~~
Bronx, NY 10467

Dear Benjamin Holmes:

Thank you for your dedicated service to the New York City Department of Parks and Recreation. We hope that you have found your seasonal employment both educational and rewarding. As you are already aware, your temporary position with our agency will end on 11/18/2006. This information has already been given to the Human Resources Administration (HRA) for the purpose of rebudgeting or restoring your public assistance case. You do not need to give this information to HRA at this time.

If you have not yet secured permanent employment you must apply for Unemployment Insurance Benefits by calling (888) 209-8124 after your last day of work. Failure to apply for unemployment insurance if you are eligible may jeopardize your eligibility for public assistance. HRA will call you into a Job Center to receive an employment assessment and appropriate work activities that will be determined upon discussion with you and the Worker at your Job Center appointment. HRA will require you to bring proof of your application for UIB to your call-in appointment. You will receive a separate notification from HRA for this interview. If you have obtained unsubsidized employment, please bring documentation regarding your new job, such as a letter of employment and/or paystub, to this interview. Should you have any questions concerning your public assistance case, call HRA at (212) 643-2881 x269.

Again, many thanks for your service and best of luck in your future efforts.

Sincerely,

David Terhune
Director of Personnel

cc: Seth Diamond
BX21105

City of New York
Parks & Recreation

The Arsenal
Central Park
New York, New York 10021

Henry J. Stern
Commissioner

Joseph P. Bernstein
Director of Labor Relations

(212) 360-8209
teamster@parklan.ci.nyc.ny.us

January 3, 2001

Mr. Mark Rosenthal
President, Local 983
District Council 37
125 Barclay Street, Rm 534
New York, New York 10007

Grievance # R01-0101-KC1522
Grievant: Benjamin Holmes

Dear Mr. Rosenthal:

As requested, a **Seasonal Review** for the above reference employee has been scheduled for Tuesday, January 9, 2001 in the Arsenal, 830 5th Ave. (located inside Central Park at East 64th St. and 5th Ave.). The hearing will begin **promptly** at 10:00 am and will take place in the Labor Relations Division (2nd Floor, Room 209). Please attend on time, as other hearings may be scheduled immediately afterwards. It may also help if you meet with the grievant **prior** to the scheduled start of the hearing, as the allotted time will be needed for the hearing itself.

Additionally, you must **notify the grievant** of the date, time and location of the hearing. Due to past confusion regarding employee addresses, this office will no longer notify grievant directly. However, as in the past, the borough/bureau office will be copied on this letter so they are aware that the employee will not be at work. If the grievant cannot attend, please provide documentation to this office so we may consider rescheduling. No-shows, undocumented absences, or avoidable absences **may** not be offered a new date.

Finally, have either yourself or the grievant bring originals of any exhibits you plan to submit, as well as two copies (one for the Union and one for the Agency).

Please feel free to call me at (212) 360-8209 with any questions you may have or any special accommodations needed for yourself or the grievant. Thank you.

Sincerely,

Joseph Bernstein

Cc: Terhune

City of New York
Parks & Recreation

The Arsenal
Central Park
New York, New York 10021

Henry J. Stern
Commissioner

Joseph P. Bernstein
Director of Labor Relations

(212) 360-8209
teamster@parklan.ci.nyc.ny.us

January 5, 2001

Benjamin Holmes
1135 East 226th Drive Apt 2B
Bronx, NY 10466

Dear Mr. Holmes:

This is to inform you that the seasonal review regarding your placement to unsatisfactory list was scheduled for January 9, 2000 in error. Article XX Section 4 of the Seasonal Agreement sets forth the following language specifically for Rights to Review or Hearing;

> *When a City Seasonal Aide employed by the Department of Parks & Recreation who has completed one season and who has worked at least ninety (90) cumulative days with the Department of Parks and Recreation in a seasonal capacity, is* ***terminated****, the employee or union representative may request a review by the Commissioner or..."*

Since you were not terminated, your request to a seasonal review is dismissed.

Sincerely,

J. Bernstein

Joseph P. Bernstein
Director of Labor Relations

CC: M. Rosenthal –President L. 983

BAP

VR

BRONX MUNICIPAL HOSPITAL CENTER — ADULT EMERGENCY ROOM SERVICE

Chart # 1871037 Age 32
Name Holmes Benjamin Sex M
Address 1135 E. 226 Dr Apt. # 2B
BX Zip # 66
DOB 4-19-53 Tel. # 798-1295
Father's Full Name unk
Mother's Full Maiden Name unk

☐ COMPENSATION ☐ LIABILITY
Print Employer's Name
Emp. Address
Tel. No.
Blue Cross Other Ins.
Arrived Via CAD From
MRE # MD #
Police Pct. Badge #
Name (Next of Kin) Tel. #

TRIAGE

Presenting Complaint Pt c̄ no PPMH Nurse's Int'l J O'Flaherty
c/o pain on Ⓛ side of chest & Ⓛ breast
Possible Dx pain awoke pt from sleep is non-radiating Triage Classif
☐ Order Chart Date and Area of Last Pertinent BMHC Treatment: P-76 Reg

T 97.4	P 76 Reg	R 18	BP 130/102	State of Consciousness A+O

HISTORY

32 y.o. O c̄ h/o HTN - c/o 3d constant knife like Ⓛ Breast/Chest pain - No ↑ c̄ Resp -, ↓ c̄ Exertion, +/- Rel. to food - No SOB, diaphoresis, N+V, cough, sputum, ETOH

PHYSICAL EXAM

PE WD/WN BO ... NAD
L — Clear
Car - S1 S2
Abd - soft ⊕BS
Chest Wall - No Pain to Palp.

☐ X-Ray
☒ EKG NSR @ 75, NL interval / Axis, ↑ J pts
☐ CBC
☐ Chemistry
☐ Urinalysis
☐ Other

DIAGNOSIS

1. Atypical CP
2. HTN
3.

TREATMENT

STAT DRUG ORDER	TIME	NURSE INT'L
1.		
2.		
3.		
4. Tet Toxoid ☐		

Drug Allergy Yes ☐ No ☒ NKA

Discharge Medication	Dose	Duration
1. Maalox		
2.		
3.		

DISPOSITION

☐ Social Service
☐ Admitted Ward
☐ Instruction given & type:
☐ Follow-up Nurse
☐ (See Reverse)
☐ OPD Clinic Date: Time:
☐ Other

PHYSICIAN PRINT NAME and INITIAL

JUN 26 4 17 AM '86

May-31-2010
Benjamin Holmes
P.O. Box 764
Bronx New York 10464
WCB Case Number 07925837

To Whom it May Concern
I Benjamin Holmes Requesting a Hearing
My Employer names was Louis Lean and
Leepole Bronetta my Carrier is State Insurance Fund
I never got a Sellerment From the Insurance
Company I was put on 50 Percent Disability in
1985 I ame Sending all the paper Worke
you ask For.

Thank you
Benjamin Holmes
Case # 07925837

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S REQUEST FOR FURTHER ACTION

INSTRUCTIONS: To request Board action on a case, complete this form and submit it to your local WCB district office. See mailing addresses on the reverse side. ATTACH ALL APPLICABLE EVIDENCE FOR CONSIDERATION BY THE BOARD. You must also send a copy of this form to your employer's workers' compensation insurance carrier, or directly to your employer or its third party administrator, if it is self-insured. This form is NOT to be used to APPEAL a decision.

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS		3. SOCIAL SECURITY NO.	4. DATE OF INJURY (mm dd yy)	5. WCB DISTRICT OFFICE
1. WCB CASE NO.	2. CARRIER CASE NO. (If known)			
0792587	State Fund- 100 42 3996		04 19 53	

NAME		ADDRESS TO WHICH NOTICES SHOULD BE SENT	APT. NO.
6. CLAIMANT	Benjamin Holmes	P.O. Box 764 Bronx N.Y. 10469	
7. EMPLOYER	Louis Leon	1101 Grand Place Bronx NY 10466	
8. CARRIER	State Fund		
9. ATTORNEY OR LICENSED REP.			ATTY/REP I.D. NO. R

CHECK HERE ☐ IF CLAIMANT'S ADDRESS SHOWN ABOVE IS NEW.

REASON FOR THIS REQUEST

(Check all that apply - use item p. for explanation or additional information - see reverse side for further explanation)

10. CLAIMANT

- ☒ a. requests referral for Administrative Determination/Conciliation/Hearing, as appropriate, because *(please check the appropriate box[es] below)*:
- ☐ b. he/she has had a change of medical condition. *IF THIS BOX IS CHECKED, ATTACH MEDICAL REPORT. IF REPORT WAS PREVIOUSLY SUBMITTED, IDENTIFY IT IN ITEM P BELOW BY DATE, DOCTOR'S NAME AND FORM ID, IF ANY.*
- ☒ c. he/she is not working and not receiving payments.
- ☐ d. his/her payments have been suspended/reduced.
- ☐ e. he/she has returned to work at full wages.
- ☐ f. he/she is working at reduced earnings.
- ☐ g. he/she has not been paid as directed in a notice of decision.
- ☐ h. a request for medical treatment was denied or not addressed.
- ☐ i. a request for medical and transportation reimbursement was denied.
- ☐ j. he/she now has medical evidence of permanency.
- ☐ k. new or requested evidence is now available.
- ☐ l. claimant's representative's fee has not been paid.
- ☐ m. he/she has discontinued or settled a lawsuit pertaining to this accident/injury.
- ☐ n. claimant has a change of address (please provide new address in 6., above).
- ☐ o. he/she has been released from incarceration and is applying for benefits (attach proof of release).
- ☐ p. other (explain fully in the space provided below.)

ATTACH ALL APPLICABLE EVIDENCE FOR CONSIDERATION BY THE BOARD. IF MEDICAL EVIDENCE WAS PREVIOUSLY SUBMITTED, IDENTIFY IT BY DATE, DOCTOR'S NAME AND FORM ID, IF ANY, IN THE SPACE PROVIDED ABOVE.

11. Have the above issues been resolved by agreement? ☐ Yes ☒ No If Yes, please attach documentation.
If No, have you attempted to resolve the issue(s) checked above with the other parties? ☐ Yes ☒ No

I hereby certify that a copy of this form with attachment(s) was submitted to the other party(ies) in this case in accordance with the instructions above.

PREPARED BY (Please Print Name)	DATE PREPARED (mm dd yy)	AREA CODE TELEPHONE NUMBER
Benjamin Holmes	05 31 10	917 971 4738

Benjamin Holmes

This form is submitted by ☐ claimant ☐ claimant's representative

RFA-1 (8-09)

SEE IMPORTANT INFORMATION ON REVERSE - VEA INFORMACION IMPORTANTE AL DORSO

Worker's **Compensation**
http://www.wcb.state.ny.us/

Property and Casualty Bureau
NYS Insurance Department
25 Beaver Street
New York, NY 10004-2319
Phone 212 480-5662

Is this where you have already tried?

Worker's **compensation records** are available by mail only. Written request must include full name, case number, name of employer involved in claim, and date of accident. Notarized release required. Fee per request.

To Whom it my Concern
I Benjamin Holmes Requesting Records for State Insurance Fund my name is Benjamin Holmes my Employer name was Louis Leon and Leeipole Bronzatto Dat of Accident 7/30/79 to 7/30/80 the address of the Place was 1101 GRinara Place Brona N.Y - 10466 Place name was GRinara GulF my WCBcase number 07925837 my currier case number 050494331 I never got a Selterment From State Insurance Fund becouse of third party accretion

Thank You
Benjamin Holmes

TAOFIK IFAFORE
NOTARY PUBLIC, STATE OF NEW YORK
No.01IF6217366
QUALIFIED IN BRONX COUNTY
COMMISSION EXPIRES FEBRUARY 8, 2014

4-1-10

This is to Show

(7296)35495938-1

State of New York
WORKERS' COMPENSATION BOARD

NOTICE OF WORKERS COMPENSATION HEARING

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board 1 Larkin Plaza (Dock Street) Yonkers, NY 10701	2	02/10/2010	9:00 AM 20 Min	Peekskill (866) 746-0552
	WCB Case No.		Date of Accident	WCB Home Page
	G0123585		07/30/1979	www.wcb.state.ny.us
			Carrier ID No.	Carrier Case No.
			W204002	
			CLAIMANT	
			Benjamin Holmes	

[redacted]
Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

CLAIMANT: Bring this notice with you. Read important information on reverse side.

EMPLOYER Louis Leon

CARRIER State Insurance Fund

07925837

COPIES TO Benjamin Holmes
Joseph A. Romano Law Offices

PLEASE NOTE: THIS HEARING WILL BE HELD AT THE YONKERS CUSTOMER SERVICE CENTER. THE HEARINGS ARE HELD ON THE 2ND FLOOR. PHONE NUMBER: 1-866-746-0552. PLEASE BE PREPARED TO SHOW PHOTO IDENTIFICATION UPON ARRIVAL.

PURPOSE OF HEARING:

C-7 issues.

IMPORTANT INFORMATION FOR THE CLAIMANT:

In a compensable workers' compensation case, bills for related medical treatment are the responsibility of your own employer or its workers' compensation insurance carrier. If you have used a private health insurance policy (Blue Cross, Blue Shield, G.H.I., H.I.P., or other) for payment of any bills in your workers' compensation case, please advise the private health insurer immediately.

In order to be reimbursed for any payments or co-payments you may have made for treatment or services which are the responsibility of the workers' compensation insurance carrier, you must tell the judge at this hearing about this payment.

The New York State Workers' Compensation Board prohibits visitors, employees, clients or witnesses from carrying or bearing firearms or any other weapon on Board premises.

'20/2010
19

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

(7295)35495908-1

NOTICE OF WORKERS COMPENSATION HEARING

State of New York
WORKERS' COMPENSATION BOARD

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board 1 Larkin Plaza (Dock Street) Yonkers, NY 10701	2	02/10/2010	9:00 AM 20 Min	Peekskill (866) 746-0552
	WCB Case No.		Date of Accident	WCB Home Page
	07925837		07/30/1979	www.wcb.state.ny.us
			Carrier ID No.	Carrier Case No.
			W204002	050494331
			CLAIMANT	
			Benjamin Holmes	

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

CLAIMANT: Bring this notice with you. Read important information on reverse side.

RECEIVED
FEB 10 2010
NYS WORKERS' COMPENSATION BOARD
YONKERS CUSTOMER SERVICE CENTER

G0123585

EMPLOYER Louis Leon D/B/A
L. L. Gulf Gas Station

CARRIER State Insurance Fund

COPIES TO Benjamin Holmes
Joseph A. Romano Law Offices

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PURPOSE OF HEARING:

C-7 issues.

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Dated: 01/20/2010

EC-16 (6/99) 4

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(5789)34546265-1

State of New York
WORKERS' COMPENSATION BOARD

NOTICE OF WORKERS COMPENSATION HEARING

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board 1 Larkin Plaza (Dock Street) Yonkers, NY 10701	2	09/16/2009	10:30 AM 15 Min	Peekskill (866) 746-0552
	WCB Case No.		Date of Accident	WCB Home Page
	07925837		07/30/1979	www.wcb.state.ny.us
			Carrier ID No.	Carrier Case No.
			W204002	050494331
			CLAIMANT	
			Benjamin Holmes	

Benjamin Holmes
1160 Burke Ave
Bronx, NY 10469-5021

CLAIMANT: Bring this notice with you. Read important information on reverse side.

EMPLOYER L. L. Gulf Gas Station

CARRIER State Insurance Fund

RECEIVED
SEP 16 2009
G0123585 NYS WORKERS' COMPENSATION BOARD
YONKERS CUSTOMER SERVICE CENTER

COPIES TO Benjamin Holmes
Joseph A. Romano Law Offices

PLEASE NOTE: THIS HEARING WILL BE HELD AT THE YONKERS CUSTOMER SERVICE CENTER. THE HEARINGS ARE HELD ON THE 2ND FLOOR. PHONE NUMBER: 1-866-746-0552. PLEASE BE PREPARED TO SHOW PHOTO IDENTIFICATION UPON ARRIVAL.

PURPOSE OF HEARING:

This claim is ordered for an Expedited Hearing pursuant to Workers' Compensation Law Section 25(3)(d) and 12 NYCRR 300.34.

The purpose of this expedited hearing is to address any and all outstanding issues at one hearing where appropriate. Within twenty (20) days from this notice, but not later than ten (10) days before the date of the expedited hearing, each party shall file with the board and serve upon all other parties in interest a concise statement of all unresolved issues, and, where necessary, a summary of the claim, a theory of the case, a list of all defenses the carrier is raising, the names of additional parties, the names of lay witnesses and medical witnesses, and an explanation as to why discovery is not completed prior to the hearing. A Board form entitled "Pre-Hearing Conference Statement" (PH-16.2.0) shall be used for this purpose.

Failure to file the pre-hearing conference statement, or filing an improper, incomplete or untimely pre-hearing conference statement will result in a waiver of defenses or a waiver of the right to call witnesses or produce evidence that should have been included with the pre-hearing conference statement.

There shall be no cancellation, adjournment, or continuance of this expedited hearing unless the WCL Judge approves based upon an emergency. An emergency is a serious event that occurs preventing the timely completion of some action ordered or directed by the Board or regulation. An emergency includes death in the family, serious illness, significant prior professional or business commitment, and inclement weather that prevents travel. It does not include any event that can be prevented or mitigated by the timely taking of reasonable action.

Any party seeking to cancel, adjourn or continue this hearing prior to its scheduled date shall file with the WCL Judge a written request at least fifteen (15) days prior to the hearing date stating the reasons for the request. Copies of such request shall be served on the other parties. If the cancellation, adjournment, or continuance is approved by the WCL Judge, an expedited hearing will be rescheduled at the earliest date possible and the parties will be notified. If the cancellation, adjournment, or continuance is denied, the hearing will take place on the date scheduled above. If the WCL Judge rules that the request for a cancellation, adjournment, or continuance is not an emergency and is frivolous, penalties of $500 or $1000 will be assessed against the requestor pursuant to WCL 25(3)(d) and 12 NYCRR 300.34(f). Such penalty will be payable by the representative making the request and shall not come out of claimant's award. No penalty shall be imposed on an unrepresented claimant

Dated: 08/25/2009

EC-16 (6/99) 65

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(6159)35787678-1

State of New York
WORKERS' COMPENSATION BOARD

NOTICE OF WORKERS COMPENSATION HEARING

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board 1 Larkin Plaza (Dock Street) Yonkers, NY 10701	2	03/22/2010	3:00 PM 90 Min	Peekskill (866) 746-0552
	WCB Case No.		Date of Accident	WCB Home Page
	07925837		07/30/1979	www.wcb.state.ny.us
	Carrier ID No.		Carrier Case No.	
	W204002		050494331	
	CLAIMANT			
	Benjamin Holmes			

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

CLAIMANT: Bring this notice with you. Read important information on reverse side.

EMPLOYER Louis Leon D/B/A
L. L. Gulf Gas Station

CARRIER State Insurance Fund

G0123585

COPIES TO Benjamin Holmes

PLEASE NOTE: THIS HEARING WILL BE HELD AT THE YONKERS CUSTOMER SERVICE CENTER. THE HEARINGS ARE HELD ON THE 2ND FLOOR. PHONE NUMBER: 1-866-746-0552. PLEASE BE PREPARED TO SHOW PHOTO IDENTIFICATION UPON ARRIVAL.

PURPOSE OF HEARING:

3/22/10 at 3:00 p.m. Testimony of claimant, 2 employer witnesses, and summations. Question of prima facie medical evidence.

IMPORTANT INFORMATION FOR THE CLAIMANT:

In a compensable workers' compensation case, bills for related medical treatment are the responsibility of your own employer or its workers' compensation insurance carrier. If you have used a private health insurance policy (Blue Cross, Blue Shield, G.H.I., H.I.P., or other) for payment of any bills in your workers' compensation case, please advise the private health insurer immediately.

In order to be reimbursed for any payments or co-payments you may have made for treatment or services which are the responsibility of the workers' compensation insurance carrier, you must tell the judge at this hearing about this payment.

The New York State Workers' Compensation Board prohibits visitors, employees, clients or witnesses from carrying or bearing firearms or any other weapon on Board premises.

Dated: 03/02/2010

EC-16 (6/99) 47

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Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.state.ny.us

(866) 746-0552

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G012 3585

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 03/22/2010 involving the claim of Benjamin Holmes at the Yonkers hearing location, Judge Chaim Malks made the following decision, findings and directions:

DECISION: Claimant is directed to produce medical evidence of a causally related injury and proof of advance payment. No further action is planned by the Board at this time.

Claimant -	Benjamin Holmes	Employer -	Louis Leon
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	G012 3585	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	
District Office -	Peekskill	Date of Filing of this Decision -	03/25/2010

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

Workers Compensation Baard
P.O. Box 5205
Binghamton N.y. 139025205

To Whom it my concern
I Benjamin Holmes wont to Reopen
My case because. I ame one houndred percent disable.
I worke for L.L. Gulf Gas station.
My Employee name was Louis Leon. The year
was July 30-1979 oc 400) My WCB number is
0792583 7. and my Carrie was State Farm
My work place was 1140 Grenada Pl. Bronx N.y. 10466
My Social Security number is -100-42-3996
My Dactor office is Wilson Orthopacies Physical Therapy
75 East Gunhill Rd. Bronx N.y 10467 Phon 718 798-1000.

State Insurance Fund
199 Church Street
New york N.y. 1007
Claim No-337867676 5
or 5486931

Thank you
Benjamin Holmes
1160 Burke Ave APT 8C
Bronx New york 10469
Phon 917-971-4738 be
718-798-3602
Benjamin Holmes

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205
www.wcb.state.ny.us

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

ZACHARY S. WEISS
CHAIR

Benjamin Holmes
1160 Burke Ave
Bronx, NY 10469-5021

July 14, 2009

In response to the claimant's counsel:
In the Request for Further Action form of 06/11/2009 you indicated that your requesting a hearing on further causally related disability.

Based upon your request the Board evaluated the file, but no action can be taken until you specify the period in question and remit medical evidence in support of causally related disability and its degree for same. In addition, if the claimant has a copy of the first notice of decision noting the site(s) established, average weekly wage, etc and a copy of the last notice of decision, please remit those as well. If additional documentation is available, send copies to the Board and carrier. Thank you.

Workers' Compensation Board

Margaret Morrissey
(866)746-0552

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	07925837	Carrier ID No.:	W204002
Date of Accident:	07/30/1979	Carrier Case No.:	050494331
Employer:	L. L. Gulf Gas Station	Insurance Carrier:	State Insurance Fund

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.state.ny.us

(866) 746-0552

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G012 3585

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 03/22/2010 involving the claim of Benjamin Holmes at the Yonkers hearing location, Judge Chaim Malks made the following decision, findings and directions:

DECISION: Claimant is directed to produce medical evidence of a causally related injury and proof of advance payment. No further action is planned by the Board at this time.

Claimant -	Benjamin Holmes	Employer -	Louis Leon
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	G012 3585	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	
District Office -	Peekskill	Date of Filing of this Decision -	03/25/2010

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.state.ny.us

(866) 746-0552

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #G012 3585

NOTICE OF DECISION

keep for your records

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DECISION: Claimant is directed to produce medical evidence of a causally related injury and proof of advance payment. No further action is planned by the Board at this time.

Claimant -	Benjamin Holmes	Employer -	Louis Leon
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	G012 3585	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	
District Office -	Peekskill	Date of Filing of this Decision -	03/25/2010

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205
www.wcb.state.ny.us

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

ROBERT E. BELOTEN
CHAIR

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

January 20, 2010

In response to the claimant:
In the phone call of 01/15/2010 you indicated that you have requested a hearing.

Based upon your request the Board is scheduling the case for a hearing; you will receive a notice of hearing giving a date, time, and location in the near future.

Workers' Compensation Board

Ms. Smalls
(866)746-0552

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	07925837	Carrier ID No.:	W204002
Date of Accident:	07/30/1979	Carrier Case No.:	050494331
Employer:	Louis Leon D/B/A L. L. Gulf Gas Station	Insurance Carrier:	State Insurance Fund

Robert E. Beloten
Chair

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO BOX 5205
BINGHAMTON, NY 13902-5205
www.wcb.state.ny.us

(866) 746-0552

State of New York - Workers' Compensation Board

In regard to Benjamin Holmes, WCB Case #0792 5837

NOTICE OF DECISION

keep for your records

At the Workers' Compensation hearing held on 03/22/2010 involving the claim of Benjamin Holmes at the Yonkers hearing location, Judge Chaim Malks made the following decision, findings and directions:

DECISION: No further action is planned by the Board at this time.

Claimant -	Benjamin Holmes	Employer -	Louis Leon D/B/A
Social Security No. -		Carrier -	State Insurance Fund
WCB Case No. -	0792 5837	Carrier ID No. -	W204002
Date of Accident -	07/30/1979	Carrier Case No. -	050494331
District Office -	Peekskill	Date of Filing of this Decision -	03/25/2010

ATENCION:

Puede llamar a la oficina de la Junta de Compensacion Obrera, en su area correspondiente, cuyo numero de telefono aparece al principio de la pagina y pida informacion acerca de su reclamacion(caso).

FH# 5624973J

DATED: Albany, New York
12/07/2010

NEW YORK STATE OFFICE OF
TEMPORARY AND DISABILITY ASSISTANCE

By

Commissioner's Designee

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205
www.wcb.state.ny.us

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

ROBERT E. BELOTEN
CHAIR

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

February 11, 2011

In response to the claimant:
In the phone call of 02/09/2011 you indicated that you do not agree with the Memorandum of Board Panel Decision dated 1/26/11.

Based upon your request the Board evaluated the file, but no action can be taken because you must submit a written request for a Full Board Review. As explained, please address the issues, facts and/or findings you disagree with in writing and if you have documentation to support your claim, please remit those as well. A copy of your written request must be filed with the State Insurance Fund as well. Thank you..

Workers' Compensation Board

Margaret Morrissey
(866)746-0552

Case Information

Claimant:	Benjamin Holmes	Social Security No.:	
WCB Case No.:	07925837	Carrier ID No.:	W204002
Date of Accident:	07/30/1979	Carrier Case No.:	050494331
Employer:	Louis Leon D/B/A L. L. Gulf Gas Station	Insurance Carrier:	State Insurance Fund

State of New York
WORKERS' COMPENSATION BO.

WORKERS COMPENSATION HEARING

Place of Hearing	Part	Date of Hearing	Time	District Office
Yonkers, NY	2	02/10/2010	9:00 AM 20 Min	Peekskill

WCB Case No.	Carrier ID No.	Carrier Case No.	Date of Accident	WCB Home Page
07925837	W204002	050494331	07/30/1979	www.wcb.state.ny.us

Benjamin Holmes
P.O. Box 764
Bronx, NY 10469

POIs not sent a notice
PE Louis Leon D/B/A

42BB

G0123585

State Insurance Fund
105 Corporate Park Dr, Ste 200
White Plains, NY 10604-3814

*A0 Joseph A. Romano Law Offices
703 Yonkers Avenue
Yonkers, NY 10704

PLEASE NOTE: THIS HEARING WILL BE HELD AT THE YONKERS CUSTOMER SERVICE CENTER. THE HEARINGS ARE HELD ON THE 2ND FLOOR. PHONE NUMBER: 1-866-746-0552. PLEASE BE PREPARED TO SHOW PHOTO IDENTIFICATION UPON ARRIVAL.

PURPOSE OF HEARING:

C-7 issues.

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Dated: 01/20/2010

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EC-16.1/28 (7-99)

NOTICE OF WORKERS COMPENSATION HEARING

State of New York
WORKERS' COMPENSATION BOARD

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board **1 Larkin Plaza (Dock Street)** **Yonkers, NY 10701**	**2**	**07/07/2010**	**10:30 AM** **15 Min**	Peekskill (866) 746-0552
	WCB Case No.	07925837	Date of Accident	WCB Home Page
			07/30/1979	www.wcb.state.ny.us
			Carrier ID No.	Carrier Case No.
			W204002	050494331
			CLAIMANT	
			Benjamin Holmes	

Benjamin Holmes
PO Box 764
Bronx, NY 10469-0702

CLAIMANT: Bring this notice with you. Read important information on reverse side.

EMPLOYER Louis Leon D/B/A
L. L. Gulf Gas Station

CARRIER State Insurance Fund

COPIES TO Benjamin Holmes

RECEIVED
JUL 07 2010
NYS WORKERS' COMPENSATION BOARD
YONKERS CUSTOMER SERVICE CENTER

PLEASE NOTE: THIS HEARING WILL BE HELD AT THE YONKERS CUSTOMER SERVICE CENTER. THE HEARINGS ARE HELD ON THE 2ND FLOOR. PHONE NUMBER: 1-866-746-0552. PLEASE BE PREPARED TO SHOW PHOTO IDENTIFICATION UPON ARRIVAL.

PURPOSE OF HEARING:

C-7 issues.

IMPORTANT INFORMATION FOR THE CLAIMANT:

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Dated: 06/17/2010

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07925837

Montefiore - Moses Division
111 East 210th Street
Bronx, NY 10467
Department of Radiology

DOS 06/18/2007 ACC # 5123509 MR # 01287053 Visit # 163763543
Typed 6/18/2007 Patient HOLMES, Benjamin
Typed By JCW-DH DOB 4/19/1953
Location ER
Resident Kim, Dong Resident
Radiologist WOLF, ELLEN L MD

Requested By MEYER, ROBERT H, MD

Dr. Dong Kim, Dr. Wolf; Acc: 5123509; MRN: 01287053; DOS: 06/18/07; DOD: 06/18/07; Patient Name: Holmes, Benjamin

EXAMINATION: Portable chest radiograph.

IMPRESSION: The patient is status post mitral valve replacement. Probable discoid atelectasis at the right and left bases. Small pneumonia is not excluded. Findings slightly improved in appearance as compared to prior study.

CLINICAL INDICATION: 54-year-old male with chest pain.

INTERPRETATION: Single portable AP view of the chest has been submitted for review and is compared to the prior study June 12, 2007.

The patient is status post mitral valve replacement. There is palpable discoid atelectasis within the right and left lung bases. Small pneumonias are not excluded. This finding is sightly improved in appearance as compared to the prior study. The heart size is top normal. The osseous structures are unremarkable.

Approved by: WOLF, ELLEN, MD

ROBERT MEYER H, MD
111 E 210TH Street
BRONX, NY 10467

Confidential Patient Information

DIAG

PRINTED BY: WPHIPPS DATE: 12/16/2009

07925837

MONTEFIORE

DOSUM

MMC Moses Division

MRN: 01287053
Acct #: 164097610 (E)
PT Name: **HOLMES, Benjamin**
Attending MD:
NS Room/Bed:
Service:
Admit Date: 26-Jun-2007
Disch Date: 26-Jun-2007

Discharge Order Summary

Age: 54 DOB: 19-Apr-1953 Sex:M Dept:ED
HT: 5 ft 7 in WT: 216 lbs
CC:
DX:
Reason:
Allergies: VALSARTAN; MORPHINE; LISINOPRIL;

INTERP: English
Isolation:
Disability:

Orders	Order Mode	Status	Signed By
BASIC METAB PANEL(Chem7/Ca), once New/NW(26-Jun-2007 1149 - H) Ordered By: CAMPBELL,CARON MD	(Electronic)	Current Status: Comp/IE	Signed By: CAMPBELL,CARON MD
CARDIAC MARKERS, once New/NW(26-Jun-2007 1149 - H) Ordered By: CAMPBELL,CARON MD	(Electronic)	Current Status: Comp/IE	Signed By: CAMPBELL,CARON MD
TROPONIN-T, once New/NW(26-Jun-2007 1149 - H) Ordered By: CAMPBELL,CARON MD	(Electronic)	Current Status: Comp/IE	Signed By: CAMPBELL,CARON MD
CBC, once New/NW(26-Jun-2007 1149 - H) Ordered By: CAMPBELL,CARON MD	(Electronic)	Current Status: Comp/IE	Signed By: CAMPBELL,CARON MD
PROTHROMBIN TIME, once New/NW(26-Jun-2007 1149 - H) Ordered By: CAMPBELL,CARON MD	(Electronic)	Current Status: Comp/IE	Signed By: CAMPBELL,CARON MD
APTT, once New/NW(26-Jun-2007 1149 - H) Ordered By: CAMPBELL,CARON MD	(Electronic)	Current Status: Comp/IE	Signed By: CAMPBELL,CARON MD
URINALYSIS, once		Current Status: DC'D/ID	
URINE CULTURE, 1, once N		Current Status: Comp/IE	
TYPE/SCREEN AUT-MOS, 1, once U		Current Status: Comp/IE	
CK MB, 1, once New/NW(26-Jun-2007 1150 - H) Ordered By: UNSPECIFIED,UNSPEC	(UNKNOWN)	Current Status: Comp/IE	Signed By: NOT,USER
Chest XR-PA/Lat, 1, once Pain_____ 780.99 r chest s/p valve replacement 6/05/07 south30hall Code Status:NONE Isolation:NONE . Fall precautions:NO. Restraint:NONE		Current Status: Comp/IE	

** END OF REPORT **

PRINTED BY: WPHIPPS DATE: 12/16/2009

07925837

Montefiore Medical Center Laboratories
Ira I. Sussman, MD - Director
111 E. 210th Street, Bronx, NY 10467
CLIA#: 33D0669651 Tel: 718-920-4695

Physician: DOCTOR UNSPECIFIED

Patient: HOLMES, BENJAMIN
MMC MR#: MMC-01287053
DOB: 04/19/53 Age: 54 Sex: M
Location: ER MOSES EMERGENCY
SSN-100423996

Report Date: 06/28/07
Collected: 06/26/07 11:50

Request#: 07-1244310

	Results	Ref. Ranges	
Blood Bank			
ABO/Rh Type	A Pos		MOS
Antibody Screen	Negative		MOS

Performing Labs: MOS=Moses EIN=Einstein BLH=Bronx-Lebanon
AML=Quest Diagnostics-Nichols Institute, PO Box 10841, Chantilly, Virginia 20153

(** Indicates CRITICAL Values)

PRINTED BY: WPHIPPS DATE: 12/16/2009

Montefiore Medical Center Laboratories

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111 E. 210th Street, Bronx, NY 10467
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CLIA#: 33D0669651

Physician: DOCTOR UNSPECIFIED

Patient: HOLMES, BENJAMIN
MMC MR#: MMC-01287053
DOB: 04/19/53 Age: 54 Sex: M
Location: ER MOSES EMERGENCY
SSN-100423996

Report Date: 07/02/07
Collected: 06/29/07 18:18

Request#: 07-1244314

	Results	Ref. Ranges
		MOS
Urine culture Source/Body site	Clean catch	
Culture results		
No growth		

Performing Labs: MOS=Moses EIN=Einstein BLH=Bronx-Lebanon
AML=Quest Diagnostics-Nichols Institute, PO Box 10841, Chantilly, Virginia 20153

(** Indicates CRITICAL Values)

PRINTED BY: WPHIPPS DATE: 12/16/2009

MONTEFIORE Moses Emergency Department
111 East 210th Street
Bronx, NY 10467
718.920.5731

Patient: H
Triage Dat
DOB: Apr
Med Rec
Account

HOLMES, BENJAMIN
MR#01287053 ED
DOB: 04/19/1953
ACCT: 163763543

MOSES Male
: 54 yr

Nursing ED Assessment Form

Date: Time:

Advance Directives: ☑ None ☐ DNR ☐ DNI ☐ Health Proxy
Protocols: ☐ CEU ☐ Sepsis ☐ Abd. Pain ☐ Stroke ☐ Asthma
Precautions: ☐ FALL ☐ Seizure

Social History: ☐ Non-Smoker ☐ Smoker/ppd: _____ ☐ Drugs _____
☐ ETOH/amount per day: _____ Last Drink: _____
Initial Glucometer (Reference Range 70-115 mg/dL): _____ **Urine Hcg:** _____
Spiritual / Cultural Needs: Identified ☐ Yes ☐ No **Addressed** ☐ Yes ☐ No
Crisis intervention: ☐ Yes ☐ No Type:

Respiratory
Airway:
☑ Patent ☐ Obstructed
☐ Trach

Respirations:
☐ Rate
☐ Labored
☐ Accessory Muscle Use
☐ Nasal Flaring

Breath Sounds:

Clear	☐ R	☐ L
Diminished	☐ R	☐ L
Absent	☐ R	☐ L
Wheezing	☐ R	☐ L
Rhonchi	☐ R	☐ L
Crackles	☐ R	☐ L

Cough:
☐ Non Productive
☐ Productive
Color:

Cardiovascular
☐ Rhythm
☐ Pacer ☐ IACD
☐ Cap Refil: ☐ <4 sec ☐ >4 sec
☐ JVD ☐ Y ☐ N
☐ Edema ☐ Y ☐ N

Integumentary
Color:
☑ WNL ☐ Pale ☐ Flushed
☐ Mottled ☐ Cyanotic
☐ Jaundice
Temperature:
☐ Warm ☑ Cool ☐ Hot
☐ Dry ☐ Diaphoretic
Skin Integrity:
☐ Intact ☐ Y ☐ N
Describe

☐ Rash ☐ Y ☐ N
☐ Bruising ☐ Y ☐ N
☐ Pressure Ulcer
Location:
Stage:

Neurological
☐ Alert ☐ Oriented
☐ Confused ☐ Verbal
☐ Lethargic ☐ Unresponsive
☐ Combative
☐ Dizziness
Speech:
☐ Slurred ☑ Clear
☐ Aphasic
PERLA ☑ Y ☐ N
☐ Facial Droop
☐ Weakness ☐ R ☐ L
☐ Paralysis ☐ R ☐ L

Mobility:
☑ Moves All Extremities
Gait: ☑ Steady ☐ Unsteady
☐ Unable to Ambulate
☐ Injury
☐ Assist device/type:
☐ Deformity
☐ Pulses
RUE RLE
LUE LLE

Abdominal
☑ Soft ☐ Distended ☐ Firm
☐ Tender ☐ Nontender
☐ Guarding
☐ Bowel Sounds
☐ present ☐ absent
☐ Nausea ☐ Vomiting
☐ Diarrhea ☐ Lactation
☐ LMP ☐ Menopausal
☐ Gravida ☐ Para
☐ Bleeding ☐ Discharge
☐ Pad Count
☐ Dysuria ☐ Frequency
☐ Incontinence ☐ Last Void:

Safety\Universal Precautions:
☑ Bed in Low Position
☐ Bed in Prominent Area
☐ Side Rails Up x2
☐ Call Bell
☐ Family at Bedside
☐ Restraint Type:
(see flow sheet)
☐ Isolation

Barriers To Learning ☑ No Barriers ☐ Physical
☐ Cognitive ☑ Primary Language Spanish
☐ Understands English

Social ☐ Nursing Home Resident
☑ Lives with Family ☐ Y ☐ N ☐ Lives Alone ☐ Y ☐ N
☐ Social Service Notified ☐ Has help @ home

Date/Time	Print Name / Title	Signature	Initials
1015	Bork	Bork	B

MONTEFIORE

Moses Emergency Department
111 East 210th Street
Bronx, NY 10467
718.920.5731

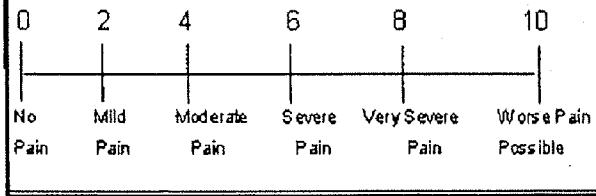
Patient: HOLMES, BENJAMIN
Triage Date: June 18, 2007
DOB: April 19, 1953 Sex: Male
Med Rec#: Age: 54 yr
Account#:

Nursing Notes -- ED Nurse Assessment Assessment Date / Time:

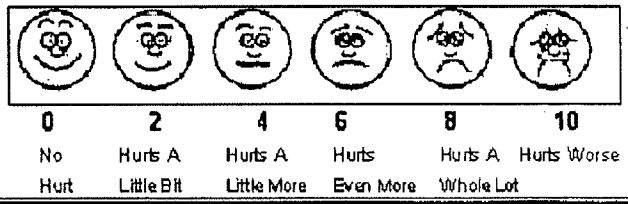
PAIN ASSESSMENT / COMFORT

Have you had pain in the past week? ☑ Yes ☐ No
Do you currently have pain? ☑ Yes ☐ No

A Descriptive Pain Intensity Scale



A Scale Using Facial Expressions (Wong-Baker Scale Faces)



DATE / TIME	INITIALS	PAIN LEVEL	INTERVENTION	RESPONSE Satisfied	RESPONSE Not Satisfied
1130	SB	5		✓	

Non Verbal Patients

If a patient is unable to communicate pain is assumed to be current if any of the following is present (check all that apply):

☐ Usually Painful Disease ☐ Painful Procedure

Patient exhibits behaviors indicative of pain such as:

☐ Frowning/Grimicing ☐ Anxious/Irritable ☐ Sad/Fearful/Withdrawn ☐ Crying/Moaning
☐ Pained Expression ☐ Restless/Agitated/Screaming ☐ Afraid To Move/Rigid ☐ Jumps When Touched
☐ No Indication Of Pain Present

DATE / TIME	INITIALS	INTERVENTION

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